ONTARIO INSULATION OSHAWA LIMITED

Workplace Incident Reporting Form – January 2024

WORKPLACE INCIDENT REPORTING FORM

GENERAL INFORMATION			
INCIDENT TYPE		**DATE (DD/MM/YYYY)**	
	Near Miss		
	Accident		
	Injury		
	Occupational Illness		
BUSINESS NAME		**NAME OF INVOLVED PERSON**	
Business Address and Phone Number		**Involved person address and phone number**	
BUSINESS'S CONTACT PERSON		**STATUS OF INVOLVED (SELECT ONE)**	
			Worker
			Customer
			Contractor
			Visitor
			Other (please specify below)
CONTACT PERSON'S PHONE NUMBER		**JOB TITLE (IF APPLICABLE)**	
ACCIDENT DETAILS			
DATE OF THE INCIDENT (DD/MM/YYYY)		**TIME OF THE INCIDENT (HH:MM)**	
DATE THE INCIDENT WAS REPORTED		**TIME INCIDENT WAS REPORTED (AM / PM)**	
LOCATION OF THE INCIDENT		**PERSON THE INCIDENT WAS REPORTED TO**	
			Supervisor
			HSR
			Other (please specify below)
SEVERITY OF INCIDENT			
	No Injury		Occupational Illness
	First Aid Injury		Lost Time Injury
	Medical aid Injury (beyond first aid)		Fatality
	Other (specify):		

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	TYPE OF INCIDENT (SELECT ALL THAT APPLY)		BODY PARTS INJURED (SELECT ALL THAT APPLY)
	Bodily reaction and exertion		Head
	Caught in or compressed by machinery or object		Multiple head locations
	Caught in or crushed in collapsing materials		Face
	Contact with electricity		Ear
	Contact with objects or equipment		Eye(s)
	Contact with temperature extremes		Neck
	Diving		Back/Spine
	Drowning or asphyxiation		Shoulder
	Elevating device damage or free fall		Chest
	Exposure to an explosion, fire, flood		Trunk
	Exposure to a harmful substance(s)		Multiple trunk locations
	Exposure to noise		Hip
	Exposure to traumatic or stressful event		Finger(s)
	Fall from height		Hand
	Harassment, Sexual Harassment		Wrist
	Heat or Cold		Upper limb
	Injury caused by an animal/insect		Multiple upper limb locations
	Lifting and handling injury		Toe(s)
	Overexertion		Foot
	Physical assault, violence		Leg
	Repetitive motion		Ankle
	Road traffic accident		Knee
	Rupture/fire boiler or pressure vessel		Lower limb
	Slip, trip or fall (same level)		Multiple lower limb locations
	Struck against object		Multiple locations
	Struck by moving vehicle		Unknown
	Struck by object		Other (specify below)
	Rescue, revival, or similar emergency		
	Other kind of accident (please describe)		

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REPORTING PERSON'S DESCRIPTION OF THE ACCIDENT / INCIDENT / INJURY
Describe the incident in detail, including details regarding any injuries that were suffered. Include information about the specific location of the incident, equipment, machines, materials, tools, and people involved. Include/attach pictures if possible.
ADDITIONAL DETAILS (Pictures)

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MEDICAL AID DETAILS							
WAS FIRST AID TREATMENT GIVEN?				**NAME OF FIRST AID ATTENDANT**			
YES		**NO**					
DETAILS OF FIRST AID TREATMENT GIVEN							
PROFESSIONAL MEDICAL TREATMENT							
WAS THE INJURED PERSON TAKEN TO HOSPITAL?				**WAS THE PERSON TREATED BY A PHYSICIAN?**			
YES		**NO**		**YES**		**NO**	
IF YOUR ANSWER IS "YES", PLEASE PROVIDE THE FOLLOWING INFORMATION				**IF YOUR ANSWER IS "YES", PLEASE PROVIDE THE FOLLOWING INFORMATION**			
Name Of Hospital: Hospital Address: Mode Of Transportation (e.g., Ambulance, Own Vehicle, etc.):				Name Of Physician: Hospital Physician: Treatment Or Care Received:			

LOST TIME	
DID YOU OR THE INJURED PERSON MISS WORK TIME DUE TO THE INCIDENT / ACCIDENT? (CHECK ONE)	
	Returned To Regular Duties with No Time Lost
	Returned To Modified Duties with No Lost Time
	Had Lost Time
IF YOU OR THE INJURED PERSON DID MISS WORK, PLEASE PROVIDE THE FOLLOWING DETAILS	
HOW MANY DAYS OF WORK DID YOU OR INJURED PERSON MISS?	
WHEN DID YOU OR THE INJURED PERSON FIRST RETURN TO WORK (DD/MM/YYYY)?	

Contributing Factors

Immediate Causes: Unsafe Acts or Unsafe Conditions
Underlying Causes: Personal, Job and Organizational Factors
Root cause: A root cause is defined as a factor that caused an accident and should be permanently eliminated or modified in order to avoid reoccurrence.

IMMEDIATE CAUSE(S)	UNDERLYING CAUSE(S)	ROOT CAUSE(S)

CORRECTIVE ACTION TO PREVENT RE-OCCURRENCE			
CONTROL MEASURE (ACTION)	**TARGET DATE**	**PERSON RESPONSIBLE**	**DATE OF COMPLETION**

DECLARATIONS		
NAME OF PERSON REPORTING THE INCIDENT	**SIGNATURE**	**DATE (DD/MM/YYYY)**
I can confirm that the information in this report is true and accurate to the best of my knowledge.		
NAME OF PERSON ACCEPTING THE REPORT	**SIGNATURE**	**DATE (DD/MM/YYYY)**