ACCIDENT/INCIDENT REPORT

(Reference Policy: HR 405 – Occupational Health & Safety

Date: _________________ Time: _______________

Insurance Claim: Yes ______ No ______

WCC Claim: Yes ______ No ______

Name: ____________________________ Student ______ or Staff ______
Campus: __________________________ Student # (If applicable) _________________

Nature of Incident/Accident: (A Brief description of how it happened)

____

____

Location:

____

Injuries:

____

Treatment(s):

____

____

____

Witnesses: ____

Referral to: ____ Hospital (Hospital Name)

____

____ Family Doctor ____ Home ____ No Referral

Means of Transportation:____ Ambulance ____ Taxi _________________Other
(Please Specify)

Recommendations to avoid this type of accident in future:

____

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__________________________ _________________________

Date Casualty's Signature

____ _______________________

Name of individual who applied First Aid and Date Signature
(Please Print)

_______________________________________ _______________________

Name of administration Manager and Date Signature
(Please Print)

Copy: Human Resources Manager or Student Counsellor (as appropriate)
Occupational Health and Safety Officer
Facilities Manager