Brock University
Injury/Incident Report

For Environment, Health & Safety Use Only

Acc. Ref. #: _____

Classification:

Cm Hlth Care	Lost Time
Incident	No Treatment
First Aid	Br Athl Clin
Br Hlth Ser	Health Care

Date of Injury/Incident (D/M/YY)	Time of Injury/Incident H:MM		
		am ☐ pm ☐	Brock Employee ☐ Brock Student ☐ University Visitor ☐ Other:

Last Name	**First Name**	**Gender** Male ☐ Female ☐	**Phone #**

Address

City **Postal Code**

Age: 0-10 ☐ 11-20 ☐ 21-39 ☐ 40-59 ☐ 60+ ☐

Where did the injury/incident occur? **Building** **Floor #** **Room # / Location**

Describe injury / injuries: **Injury Type(s)** (See page 2 for reference) **Body Part (s)** (See page 2 for reference) Left Side ☐ Right Side ☐ n/a ☐

Describe any first aid treatment administered and/or medical aid to date (e.g. Physician, physiotherapy, etc.)

Injured person sent to: (Check appropriate) Brock Health Services ☐ Brock Athletic Clinic ☐ Physician ☐ Hospital ☐ Ambulance ☐ Other:

Briefly but precisely outline the sequence of events leading up to the incident or injury. Include the size, weight and type of equipment or material involved, etc. Attach a diagram if relevant.

Describe any property damage or hazardous situation, real or potential:

Names, addresses and phone numbers of witnesses or persons having knowledge of incident:

Complete this section only when the injured person is a Brock employee

Lost Time beyond date of injury: ☐ Yes ☐ No	Occupation	Department	Hire Date: D/M/YY

Normal Working Hours For Week of Injury: S M T W T F S	Supervisor	D/M/YY Supervisor Notified
_____ to _____ Total Hours _____		

D/M/YY of Birth	Social Insurance Number	Treating Physician & Address

Name of person who completed this form | Department/Extension | Date

Submission instructions:

1. Print three (3) copies
2. Send **one completed copy** to the Office of Environment, Health & Safety (OEHS) within two (2) business days of injury or incident
3. Give **one copy to your supervisor** or the person responsible for the location of the incident to complete and forward to OEHS
4. Keep **one completed copy** for your records

03/04

Injury Types:	
Amputation	Inhalation
Broken	Laceration
Bruise/Scrape	Other (explain)
Burn	Overcome
Crushed	Pinched
Dislocation	Puncture
Faint/Dizziness	Skin Irritation
Foreign Object In	Splash/Fluid
Heart Attack	Sprain
Hernia	Strain

Body Parts:	Shoulder	Buttocks
Head	Arm	Groin
Face	Elbow	Leg
Eye	Wrist	Thigh
Ear	Hand	Knee
Nose	Finger	Shin
Mouth	Thumb	Ankle
Chin	Chest	Foot
Throat	Abdomen	Toe
Neck	Back	Entire
Collar Bone	Hip	Other (explain)

Supervisor's Report

To be completed by the Brock employee responsible for the individual, or where appropriate, for the location of the incident.

Lost time beyond the date of the injury? ☐ **No** ☐ **Yes** ☐ **Possibly**

Select all contributing factors that apply:

- ☐ Unsafe equipment
- ☐ Improperly guarded equipment
- ☐ Poor "housekeeping" e.g. Clutter
- ☐ Insufficient training
- ☐ Deviation from safe practice
- ☐ Ackward position or posture
- ☐ Inadequate personal protection
- ☐ Inadequate illumination
- ☐ Hazardous environmental condition
- ☐ Other (explain):

Select all corrective measures that apply:

- ☐ Equipment repair or replacement
- ☐ Installation of guard or safety device
- ☐ Improved "housekeeping"
- ☐ Additional Training/Communication
- ☐ Changes to work procedure
- ☐ Correction of congested area
- ☐ Improved personal protective equipment
- ☐ Improved environmental conditions
- ☐ Conduct job safety analysis
- ☐ Other (explain):

Actions planned to prevent recurrence:

Proposed implementation measures date to prevent recurrence: _____

_____	_____	_____
Supervisor Signature	Department/Extension	Date
_____	_____	_____
Worker Signature	Department/Extension	Date