

Your OSH Specialist: Phone Number:

Email Address:

If you need help filling out this from contact your OSH Specialist

INJURY / INCIDENT REPORTING FORM

Person Completing the Form			
First name:	Last name:		
Email:	Phone #:		
Job Title:	Local / Unit #:	Sub-Group:	
Employer Address:			
Incident Details			
Incident Type: 🗌 Incident – With Injury	Incident – With Exposure	Hazardous Situation	🗌 Near Miss
Description of Incident /Hazard			
If multiple occurrences, provide dates			
Date of Occurrence(s):	Time of Occurrence(s))-	
Location of Occurrence(s):		/. Iding:	Room:
Specific Location:			
Was Occurence Reported To Employe	r? Y N Date Reported:	To Who	om.
Injury Details			
First name:	Last nan	ne:	
Email: Phone:			
Level of Treatment: Medical Treatment Intend to Seek Medical Treatment Lost Time Injury			
Report only First Aid Taken to Hospital			
Name of Treatment Provider:			
Nature of Injury: Cut Bruising Bite / Sting Burn Crush Dislocation Skin Reaction			
Break Strain / Sprain Numbness / Tingling Illness Other (specify)			
Body Location:			

Contributing Factors



- Lack of or inadequate plant/equipment
- □ Lack of or inadequate procedures/instructions
- □ Lack of or inadequate training
- Lack of or inadequate management/supervision
- ☐ Inappropriate or inadequate work environment
- Other (Specify)

Corrective Action(s)

Purchase or updated plant/equipment
Creation or revision of procedures/instructions
Provided training
Improved management/supervision
Changed work environment
☐ Other (Specify)
Person Responsible:
Action(s) completed: Yes No, target date for completion:
Report to be Sent toSent to SupervisorSent to Local / Unit
Supervisor:
Union Representative: