



EMPLOYEE INCIDENT REPORT – APPENDIX ‘B’

Note: FAX this form to the Human Resources Department at 274-8479 on the same day as the incident occurred and prior to seeking medical attention other than in an emergency situation. Questions: Please call Christine Ruppenstein at 274-3436 ext.279

Employee Information

Last Name	SIN
First Name	Birth Date
Address	Telephone Number
	Department
	Job Title

Details of Injury

Date of Injury (D/M/Y)	Time of Injury (AM/PM)	Date and Hour Reported To Employer
Where did the accident occur?		
Who was the injury / accident reported to?		
What happened to cause the injury?		
Explain what the worker was doing and the effort involved.		
Identify the size, weight and type of equipment or materials involved.		
Describe the injury, part of body involved and specify left or right side.		
Names of witnesses or persons having knowledge of the injury / incident.		

Health Care

Did the Worker receive health care?	Yes ()	No ()	Don't Know ()
Name and Address of Attending Physician			
Lost Time?	Yes ()	No ()	Don't Know ()

Other

Was the site of the accident visited?	By whom?
Conditions contributed to accident and the steps taken to prevent recurrence:	
Person insuring that the above steps are taken:	
When will this action be done?	

Claim Information

To your knowledge, has the employee had a previous or similar disability?	Yes ()	No ()
Comments:		
Supervisor's Signature:	Date	
Employee Signature:	Date	