## NOSM INJURY/INCIDENT REPORTING FORM

**Section A – Employees/Residents/Students:**

All employees must complete and submit this form to their supervisor as soon as possible following an injury or incident. If the employee/student is unable to complete this form, the supervisor must do so on their behalf. Please see the document titled “Injury/Incident Report Form Information Sheet” for assisting in completing this form.

### Last Name: ___________________________  First Name: ___________________________

### Job Title: ___________________________  Unit: ___________________________

### Phone Number: ___________________________  Email: ___________________________

### Supervisor: ___________________________

### DD/MM/YY of Injury/Incident: ________________  Time of Day: ________________  ☐ AM ☐ PM

### Injury/Incident Location: ___________________________  Room Number/Location: ___________________________

### Description of Injury/Incident

Briefly describe the injury/incident (include all relevant information):

### Who was the injury/incident reported to?

(Name, Position and Phone Number):

### DD/MM/YY Reported: ________________  Time of Day: ________________  ☐ AM ☐ PM

### Witnesses? If so, please provide name(s), position & phone number:

### Type of injury:

- [ ] Incident (Near Miss)  
- [ ] First Aid
- [ ] Health Care (Medical Aid)  
- [ ] Critical Injury  
- [ ] Occupational Illness

If lost time injury, indicate DD/MM/YY last worked: ________________  Time of Day: ________________  ☐ AM ☐ PM

DD/MM/YY Returned to Work: ________________  Time of Day: ________________  ☐ AM ☐ PM

### Indicate the injured body part, and if it was the Left, Right, or Both Sides:

- [ ] Head  
  - Left  
  - Right  
  - Both

- [ ] Neck  
  - Left  
  - Right  
  - Both

- [ ] Shoulder  
  - Left  
  - Right  
  - Both

- [ ] Upper Arm  
  - Left  
  - Right  
  - Both

- [ ] Wrist  
  - Left  
  - Right  
  - Both

- [ ] Lower Back  
  - Left  
  - Right  
  - Both

- [ ] Lower Leg  
  - Left  
  - Right  
  - Both

- [ ] Hip  
  - Left  
  - Right  
  - Both

- [ ] Ankle  
  - Left  
  - Right  
  - Both

- [ ] Eye  
  - Left  
  - Right  
  - Both

- [ ] Ear  
  - Left  
  - Right  
  - Both

- [ ] Teeth  
  - Left  
  - Right  
  - Both

- [ ] Finger(s)  
  Please Specify:

- [ ] Other (please specify):

### Did you receive health care for your injury?  
- [ ] Yes  
- [ ] No

If yes, include the health professional’s name, address and phone number:

- Name: ___________________________
- Address: ___________________________
- Phone: ___________________________
Section B – Supervisors

Section B must be completed and submitted (along with Section A) to Human Resources by the supervisor within 24 hours of learning of the injury/incident. See the document "Injury/Incident Report Form Information Sheet" for assistance in completing the form or contact the Human Resources Unit.

Note: Failure to submit the form within 24 hours of the injury/incident may result in the unit being charged a late reporting fine as imposed by the Workplace Safety and Insurance Board (WSIB).

Supervisor Name: __________________________ Unit/Portfolio: __________________________ Extension: __________________________

Contributing Factors – Check all that Apply

☐ Awkward Positioning/Posture (ergonomics) ☐ Unsafe Equipment/Machinery
☐ Slip/Trip/Fall (include description of footwear): ☐ Deviation from Safe Practice/Procedure
☐ Improperly Guarded Equipment/Machinery ☐ Failure to Lockout
☐ Failure to use Personal Protective Equipment ☐ Incorrect/Defective Tool(s)
☐ Unsafe Practice ☐ Other:
☐ Poor Housekeeping
☐ Insufficient Training

Detailed Explanation of Contributing Factor(s):

Details of Property Damage, if Applicable:

Corrective Measures – Check all that Apply

☐ Additional/Refresher Training ☐ Improve Housekeeping ☐ Review Personal Protective Equipment
☐ Equipment Repair/Replacement ☐ Install Guard/Safety Device ☐ Change to Work Procedure
☐ Conduct Job Safety Analysis ☐ Discuss during Employee Orientation ☐ Other (Please Explain):

Detailed explanation of corrective measure(s) taken to prevent reoccurrence:

Supervisor Signature __________________________ Date __________________________

Human Resources Signature __________________________ Date __________________________

COMPLETED FORMS MUST BE SENT TO HUMAN RESOURCES:

EMAIL: hr@nosm.ca or FAX: (705) 671-3880