



# ACCIDENT/INCIDENT REPORT

To be completed by Employee/Student				PLEASE COMPLETE AS FULLY AS POSSIBLE	
Last Name	First Name	Date of Report			
Street Address	City	Postal Code			
Home Telephone	Work Telephone	Date of Birth			
Job Title (or student/visitor)	Location where injury/incident took place (Campus/Building/Room Number)				
<b>If Student, faculty enrolled in:</b>					
Date & Time of Injury/Incident:	First reported to: (name)				
	Supervisor _____				
	First Aid Attendant _____				
	Instructor _____				
Date & Time Reported:	Supervisor/Instructor in charge at time of injury				
Signature of person reporting:					
<b>To be completed by Supervisor and/or First Aid Attendant Name:</b>					
Names and addresses of witnesses:					
Accident/Incident category	No injury	Medical treatment	Property damage	Fire	Other (please specify)
Severity of injury or illness	No injury First Aid only	Medical treatment	Disabling	Fatal	
Nature of injury or illness					
Description of incident/accident (or employee's account of illness)					

Please describe the results of incident or illness (Property damage, type of injury, nature of illness,) first aid required and disposition (return to work, to medical care etc.)

*If there is any time loss or if you see a doctor at a later date, you **must notify your supervisor/instructor and the must notify your supervisor/instructor and the Employee Relations Office immediately to ensure that the appropriate forms are filed with the Workers' Compensation Board. (Employees, apprenticeship or student's on practicum)***

**see next**

Accident/Incident Report Page 2:

To be completed by Supervisor/Instructor Name:	YES	NO
Were persons actions at time of injury/incident for the purpose of UCFV business?  If NO, please explain:		
Were they part of his/her regular work?  If NO, please explain:		
Was any person not employed by UCFV to blame for this injury/incident?  If YES, please provide name and address of such person below.		
Are you aware of any previous pain or disability in the area of the present injury?  If YES, please explain		
Are you aware of any pre-existing injury or disability of the worker prior to injury?		

If YES, please explain:

What was the basic cause (and contributory cause(s) if any) Please explain fully any unsafe act, condition or personal factor:

**Supervisor/Instructor Signature:** Date:

**To be completed by Safety Coordinator:**

**Corrective measures taken and/or recommended:**

**Corrective action referred to:**

**To be completed by:**

Name and occupations of persons who investigated accident:

**Completed form to be forwarded IMMEDIATELY to Safety and Security Office, Abbotsford Campus B244E. *In the event of a serious accident, phone the In the event of a serious accident, phone the Manager, Safety and Security immediately so that a full investigation of the incident may commence (Local 4603).***