Employee Incident/Injury Report Form

Step 1 — **Instructions for: Injured Employee or Designate**

1. Report to designated First Aid Attendant (mandatory) or if after hours to the designated Site Manager/Administrator verbally by phone.
2. **Complete Form 6A:** Employee's Report of the Employee Incident/Injury Report Form. Form 6A can be obtained from the Site secretary or online at http://www.worksafebc.com/forms/
3. After receiving First Aid, contact your Manager/Principal/Supervisor to report the injury.
4. Immediately fax or email to the Claims Processing fax number: (250) 992-0409 or email tracyruether@sd28.bc.ca .
5. Retain the Form 6A for **your** records.

Note: A designate may complete Form A when the injured employee is unable to do so or when the employee is absent from work.

Claims Processing:
Immediately fax to:
Fax No.: (250) 992-0409
Telephone No.: (250) 992-0404
tracyruether@sd28.bc.ca

If you have questions call
District Health and Safety: (250) 992-0404

Step 2 — **Instructions for: First Aid Attendant(s)**

1. First Aid assessment and treatment must be carried out by persons that have a valid First Aid Certificate as part of WCB regulation.
2. First Aid attendants complete the First Aid Report and Patient Assessment and submits to the site manager.

Step 3 — **Instructions for: Investigator(s)**

1. The investigation must be carried out by persons who are knowledgeable in conducting an Incident Investigation, knowledgeable of the type of work involved, and should include the participation of a worker representative if feasible.
2. **Complete Section A:** Investigator's Report - General

Note:
Depending on the type of injury, Section A may prompt you to complete Section B and/or C. Please make sure that all applicable Sections are completed where required.

Fax or email the report form to your Claims Processing.

If you require additional space for comments:
Please use a separate sheet of paper and submit with the Employee Incident/Injury Report Form or Investigation Form

SECTION A: INVESTIGATOR'S REPORT

Identify Accident Type: *(√)*

- ☐ Struck Against or Struck by Object
- ☐ Slip, Trip or Fall
- ☐ Caught in, Under or Between
- ☐ Exposure to or Contact with Harmful Substance (excluding blood/body fluids)
- ☐ Exposure to Blood or Body Fluids – Complete Section D
- ☐ Car or Transportation Accident
- ☐ Act of Violence (Complete Threat/ Violence Report)
- ☐ Bodily Reaction
- ☐ Overexertion – Complete Section C
- ☐ Repetitive Motion – Complete Section C
- ☐ Other

Identify All contributory Factors: *(√)*

Equipment

- ☐ Faulty –equipment known to be faulty before incident
- ☐ Faulty –equipment not known to be faulty before incident
- ☐ Used for something other than its intended purpose
- ☐ Used in accordance with manufacturer's instructions
- ☐ Other –specify under additional contributory factors

Environment

- ☐ Wet/slippery conditions
- ☐ Over-crowding or confined working space
- ☐ Noise
- ☐ Lighting
- ☐ Climate/temperature
- ☐ Other – specify

Immediate Corrective Action Taken:

Recommendations for Further Follow-up:

Name of Investigator(s)	Signature:	Date:

SECTION B: INVESTIGATOR'S REPORT SPRAINS, STRAINS, REPETITIVE MOTION INJURIES

ACTIVITY BEING PERFORMED

What activity was involved? *(√)*

- ☐ Carrying an object
- ☐ Lifting an object from floor
- ☐ Catching something or someone from fall
- ☐ Pushing/pulling an object
- ☐ Supporting a student while walking
- ☐ Transfer to/from wheelchair/chair/ toilet/change table
- ☐ Repositioning student in chair
- ☐ Prolonged "hold" or "support" of student/object
- ☐ Mechanical lift
- ☐ Other (describe) _____

_____

What weight was involved? _____

What procedure was used? *(√)*

- ☐ Balance and stability
- ☐ Carrying a load
- ☐ General lifting
- ☐ Pushing/pulling objects
- ☐ Lifting from/lowering to floor
- ☐ Assisted walking
- ☐ Transferring Student
- ☐ Lifting student
- ☐ Providing personal care
- ☐ Mechanical lift
- ☐ 2 person supported lift
- ☐ Other (describe) _____

Contributory factors? *(√)*

- ☐ Load awkward to carry
- ☐ Load positioned or carried away from the body
- ☐ Load shifted/unexpected motion/momentum of object/equipment
- ☐ Move/lift not coordinated (1-2-3 lift)
- ☐ Employee unfamiliar with or not trained in safe work procedure
- ☐ Lift/transfer procedure used was inappropriate for situation
- ☐ Appropriate mechanical lift not used
- ☐ Uncooperative or aggressive action
- ☐ Other (describe) _____

EQUIPMENT, ENVIRONMENT, DESIGN

If equipment contributed: (√)

	Yes	No
Was it readily available?	☐	☐
Was it in good working order?	☐	☐
Was it tagged defective?	☐	☐
Was employee trained in use?	☐	☐
Was it used for intended purpose?	☐	☐

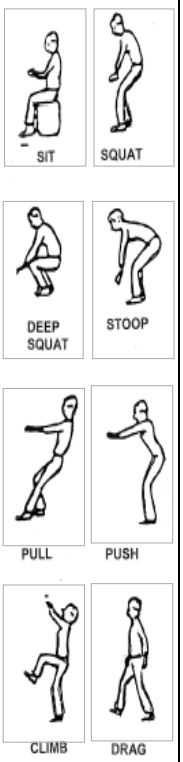
Other contributory factors: (√)

	Yes	No
Wet or slippery floor	☐	☐
Crowded conditions	☐	☐
Furniture design/location	☐	☐
Equipment design/location	☐	☐
Workstation design	☐	☐
Weight (specify) _____		
Working above shoulder height	☐	☐
Working below knee height	☐	☐
Working away from body	☐	☐

Other (describe) _____

_____

Circle Posture Involved



Immediate Corrective Action Taken:

Recommendations for Further Follow-up:

Name of Investigator:	Signature:	Date:

SECTION C: INVESTIGATOR'S REPORT — BLOOD AND BODY FLUID EXPOSURES

Identify All Appropriate Responses: *(√)*

- ☐ Concealed needle/sharp i.e. in garbage
- ☐ During/after disposal of needle/sharp
- ☐ Action of student. If so, name _____
- ☐ Action of non-student. If so, name _____
- ☐ Other (describe) _____

Identify Type of Exposure: *(√)*

- ☐ Contaminated needle/sharp. If source of contamination known indicate the source (person's first & last name) _____
- ☐ Unused, clean or sterile needle/sharp
- ☐ Direct contact to skin, eyes, nose or mouth
  What body fluid was worker exposed to?: _____

Identify All Contributory Factors: *(√)*

- ☐ Equipment (specify) _____
- ☐ Environment (specify) _____
- ☐ People (specify) _____
- ☐ Procedure (specify) _____

SECTION D: PRINCIPAL / MANAGER'S REPORT

Yes	No	
☐	☐	Do you have any concerns regarding this claim?
☐	☐	Do you have any additional information relevant to this claim?

Corrective Action Taken (specify):

Injured Employee's Name: _____

Facility: _____

Yes	No	
☐	☐	Is there a written safe work procedure for activity involved?
☐	☐	Has employee received education and/or training relevant to the activity involved? If yes specify date: _____
☐	☐	Did the employee report to first aid immediately?
☐	☐	Did the employee see an emergency or family physician?
☐	☐	Was there any time loss subsequent to the injury date? If so, specify dates _____
☐	☐	If time loss, is there an opportunity for this employee to return to work via a graduated or modified program?

Name:	Signature:	Date:

FOR COMPLETION AND DISTRIBUTION INSTRUCTIONS SEE FRONT COVER