APPENDIX B

Accident/Incident Report

Department	Division
Location	Name of person making this report
Supervisor	Date/Time of accident/incident
Location of theaccident/incident	Date/Time reported to employer
Name of person injured	Occupation
Was medical treatment received? Yes ☐ No ☐	Will there be time lost from work? Yes ☐ No ☐
Part of the body injured	Nature of injury (i.e. sprain)
Was this a recurrence? Yes ☐ No ☐	Were WCB forms filed? Yes ☐ No ☐

Describe clearly how the accident/incident occurred. ______________________

Describe clearly accident/incident causes. Conditions (human; physical; mechanical; environmental etc.):

Other factors (weather; training etc.): ______________________

______________________ **Employee Signature** ______________________ **Date**

To Be Completed by Supervisor

What action has or will be taken to prevent a recurrence? ______________________

Additional notes ______________________

______________________ **Supervisor Signature** ______________________ **Date**