Accident/Incident Report

Department	**Division**
Location	**Name** of person making this report
Supervisor	**Date/Time** of accident/incident
Location of the accident/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