Prince Edward Island
CANADA

Public Service Commission

Accident/Incident Report

Department	**Division**
Location	**Name** of person making report
Supervisor	**Date/Time** of accident/incident
Location of accident/incident	**Date/Time** reported to employer
Name of person injured	**Occupation**
Did an injury occur? ☐ Yes ☐ No **If yes, Part of Body Injured:**	**Nature** of Injury (i.e. sprain, slip, trip, fall, etc.)
Was **medical treatment** received ☐ Yes ☐ No	Was this a **recurrence**? ☐ Yes ☐ No
Were **WCB forms** filed? ☐ Yes ☐ No	Will there be **time lost** from work? ☐ 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

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To be completed by Employee Wellness & Safety Department

Follow up:	
Additional notes:	
Supervisor signature	Date