INCIDENT REPORT FORM

To be completed by individual(s) directly involved with the unsafe situation or injured in the incident within 24 hours of occurrence

Instructions for completion:
1. Faculty or Staff: After completion, sign and give this form to your supervisor immediately.
2. Student, visitor or contractor: Please send completed form to Health, Safety & Wellness (complete page 1 only).
3. Supervisor/Manager: Please complete the supervisor/manager’s section found on page 2. Sign and submit the completed form to your AVP/Dean/Director.
4. AVP/Dean/Director: Review the incident report form and actions recommended by the supervisor. Sign and submit to Health, Safety & Wellness.

Name: ___________________________ Student/Faculty/Staff ID #: ___________________________
Current Address: ___________________________ Title/Occupation: ___________________________
City/Postal Code ___________________________ Department/Faculty: ___________________________
Home phone: ___________________________ Supervisor Name: ___________________________
(Required for Faculty/Staff Only)
Work phone: ___________________________ Supervisor Phone: ___________________________
(Required for Faculty/Staff Only)
Employment category:  □ Employee  □ Student  □ Faculty  □ Visitor  □ Contractor
Occurrence Date: ___________________________ Time: ___________________ am □ pm □
Location: __________________________________________________________
(Required for Faculty/Staff Only)
(Required for Faculty/Staff Only)

Please describe the unsafe situation or how the incident occurred: (If more room is required, please attach a word document to incident report):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Details of injury/illness & treatment (e.g. body part involved, cut, strain, bruise, illness, symptoms and date of onset, etc.):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Was medical treatment received?  □ University Health Clinic  □ Family physician  □ Hospital  □ Other  □ No*
*Seek medical attention if symptoms arise or persist and ensure Health, Safety and Wellness department is notified.

Did this incident/injury cause you to miss time from your studies or from work?  □ Yes  □ No
- If yes, dates you missed time from your studies or from work ___________________________
- If yes, have you returned to work  □ Yes  □ No

Signature ___________________________ Date ___________________________
SUPERVISOR’S/MANAGER’S SECTION

To be completed by the supervisor within 24 hours of incident/accident

What do you believe were the causes of the unsafe situation or incident, and what preventative measures will be or have been taken to avoid a reoccurrence of this incident?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Action by: ____________________________________________________________  Action will be completed by: ____________________________
(Name)  (Date)

Supervisor’s/Manager’s Name: (please print) __________________________________

Supervisor’s Signature: ____________________________  Date: ____________________________

Manager’s Signature: ____________________________  Date: ____________________________

Manager’s Name: (please print) __________________________________

AVP/DEAN/DIRECTOR SECTION

Additional comments, if any

________________________________________________________________________

________________________________________________________________________

AVP/Dean/Director Signature: ____________________________  Date: ____________________________

Upon completion, submit this form either by email or delivery to:

Health, Safety & Wellness, Human Resources (AH 435)
Health.Safety@uregina.ca

Office Hours: Monday to Friday – 8:15 am to 4:30 pm