Delta School District *Inspired Learning*

Employee Incident Report

School Year:	**School:**
Employee Name:	**Employee #:**
Job Position/Title:	

Employee Incident Report

THIS FORM IS TO BE COMPLETED IMMEDIATELY FOLLOWING AN INCIDENT.

If the injury resulted from an incident involving a student, this form will be partially updated through the Student Incident Report which should be completed first.

Report your injury or near miss incident immediately to your supervisor.

Report your injury to WorkSafe BC by calling TELECLAIM (1-888-967-5377) if:

- you miss time from work due to the injury and/or
- your injury required medical attention (e.g. physician, hospital)

Date of Report:

Will the worker be away from work beyond the date of injury?

Has the worker seen or plan to see a qualified medical practitioner?

If one or both of these questions is checked "Yes", the Preliminary Incident Investigation needs to be completed within 2 days.

Incident Type and Classification

Type

- ☐ Near miss
- ☐ Minor injury (no external medical services or time loss)
- ☐ Major injury (external medical services and/or time loss)
- ☐ Other:

Classification

- ☐ Slip/Trip or Fall
- ☐ Assault/Violence
- ☐ Bullying and Harassment
- ☐ Property damage
- ☐ Chemical or substance release
- ☐ Property damage
- ☐ Other:

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Incident Description

Date of incident: **Time of incident:** **Location of incident:**

Date reported to supervisor: **Time reported to supervisor:**

Where did the incident occur? (Provide detailed description of where the incident occur):

What was the incident? (Provide detailed description of the incident, including the sequence of events proceeding to the incident. If the incident involved a dysregulated student, also complete a student incident form):

Statement of cause: List any unsafe conditions, acts, or procedure that in any manner contributes to the incident:

This incident was reported to:

- ☐ Supervisors
- ☐ Principal
- ☐ First Aid Attendant
- ☐ Vice Principal
- ☐ Other:

Name of person reported to:

Is there a witness to the incident or someone to who you mentioned your pain or discomfort?

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Injury Description

Area of Injury (Body Part) – Mark the appropriate box:

- ☐ Head
- ☐ Face
- ☐ Left eye
- ☐ Right eye
- ☐ Teeth
- ☐ Neck
- ☐ Chest
- ☐ Lungs
- ☐ Upper back
- ☐ Lower back
- ☐ Abdomen
- ☐ Pelvis
- ☐ Left shoulder
- ☐ Right Shoulder
- ☐ Left arm
- ☐ Right arm
- ☐ Left elbow
- ☐ Right elbow
- ☐ Left wrist
- ☐ Right wrist
- ☐ Left hand
- ☐ Right hand
- ☐ Left finger
- ☐ Right finger
- ☐ Left forearm
- ☐ Right forearm
- ☐ Left hip
- ☐ Right hip
- ☐ Left thigh
- ☐ Right thigh
- ☐ Left knee
- ☐ Right knee
- ☐ Lower left leg
- ☐ Lower right leg

Have you hurt this area of your body before?

Describe your injury (symptoms, appearances, parts of body, etc):

Health Care Information

Did you receive first aid at work?

Date of first aid:

Name of first aid attendant:

Did you receive medical care?

- ☐ Hospital
- ☐ Ambulance
- ☐ None
- ☐ Physician
- ☐ Other:

Date of medical care:

General Information

Did the incident occur on District premises or an authorized worksite?

Did the incident happen during the worker's normal shift?

Was the worker performing their regular duties at the time of the incident?

Were the worker's actions, at the time of injury, for the purpose of District business?

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Employee Declaration and Signature

I declare that the information provided in the employees report of incident is true and correct.

Name	Signature	Date