ACCIDENT INVESTIGATION REPORT

☐ DRAFT REPORT ☐ FINAL REPORT

WorkSafeBC File No. _____

Employee Name _____

Employee SIN _____

Instruction for Completion

- All fields on the cover page of the report must be completed
- Only use the fields that are required in the body of the report
- If a field is not required then place a diagonal line through it and place 'N/A' on the line and initial it
- Return completed reports and all associated information (statements, images, sketches, etc) to the Safety Manager

☐ DRAFT REPORT ☐ FINAL REPORT

Accident Investigation Report

WorkSafeBC File No.: _____ **Employee SIN No.:** _____

Employee First Name: _____ **Employee Last Name:** _____

Employee No: _____ **Supervisor Name:** _____

Date of Birth (m/d/y): _____ **Date of Accident** (m/d/y): _____ **Time:** _____

Length of Employment (years): _____ **Shift:** ☐ Day ☐ Night

Worker Classification: ☐ Administration ☐ Millwright ☐ Electrician ☐ Other:

Accident Type (Primary Cause)

- ☐ Confined Space
- ☐ Electrical contact
- ☐ Equipment (use, contact)
- ☐ Explosion / Fire
- ☐ Falls – Equipment
- ☐ Falls - Heights
- ☐ Harmful Substances
- ☐ Overexertion
- ☐ Soils cave-in / failure
- ☐ Trip / Slip
- ☐ Struck, Abraded, Caught, Rubbed
- ☐ Temperature Exposure

Injury Location

Head
- ☐ Face
- ☐ Eyes
- ☐ Ears
- ☐ Nose/Throat
- ☐ Teeth
- ☐ Neck

Trunk
- ☐ Abdomen
- ☐ Chest
- ☐ Hips
- ☐ Shoulder
- ☐ Back
- ☐ Multiple

Extremities (lower)
- ☐ Thigh
- ☐ Knee
- ☐ Leg
- ☐ Ankle
- ☐ Foot
- ☐ Multiple

Extremities (upper)
- ☐ Upper Arm
- ☐ Elbow
- ☐ Forearm
- ☐ Wrist
- ☐ Hand
- ☐ Multiple

Nature of Injury

- ☐ Abrasion
- ☐ Dislocation
- ☐ Irritation
- ☐ Amputation
- ☐ Fracture
- ☐ Laceration
- ☐ Asphyxia
- ☐ Hearing
- ☐ Sprain/Strain
- ☐ Concussion
- ☐ Burn
- ☐ Incised Wound
- ☐ Puncture
- ☐ Inhalation
- ☐ Contusions
- ☐ Internal
- ☐ Shock
- ☐ Other:

Injury Severity

- ☐ Near Miss
- ☐ Minor Accident
- ☐ Fatal
- ☐ No Lost Time
- ☐ Serious Accident
- ☐ Disaster
- ☐ Lost Time Accident
- ☐ Major Accident
- ☐ Permanent Partial Disability
- ☐ Permanent Total Disability

Scene of Accident

- ☐ Excavation
- ☐ Formwork (walls, columns, shafts)
- ☐ Ladder
- ☐ Ground Level
- ☐ Formwork (slabs, flatwork)
- ☐ Hoisting Equipment
- ☐ Elevated Structure
- ☐ Scaffolds
- ☐ Other:

Item Directly Producing Injury (Check One Only)

- ☐ Motorized Equipment
- ☐ Hand Tool
- ☐ Ladder, staging, scaffold
- ☐ Guards, barriers
- ☐ Electrical Equipment
- ☐ Pneumatic Equipment
- ☐ Personal Devices
- ☐ Housekeeping
- ☐ Moving Object
- ☐ Chemicals
- ☐ None
- ☐ Other:

ACCIDENT INVESTIGATION REPORT

☐ DRAFT REPORT ☐ FINAL REPORT

Contributing Act / Factor (Check One Only)

☐ General Rules Violation	☐ Not using proper PPE	☐ Inexperience
☐ Operating without Authority	☐ Modifying Safety Device	☐ Other:
☐ Operating without Training	☐ Unsafe Procedure	
☐ Failure to Guard	☐ Inattention	
☐ Violence	☐ Using Unsafe Equipment	
☐ Failure to Secure or Warn	☐ Improper Posture or Position	

Weather

☐ Clear ☐ Fog ☐ Inside ☐ Other ☐ Overcast ☐ Rain ☐ Snow/Ice ☐ Wind

Comments:

ACCIDENT INVESTIGATION REPORT

☐ DRAFT REPORT ☐ FINAL REPORT

Employee's Name: _____ **S.I.N.:** _____

Injuries Reported (If applicable): _____

_____

_____

Did employee have pre-accident/incident injuries or disabilities contributing to this event? Yes No

If YES please explain:

_____

_____

_____

_____

Has the employee had previous accidents/incidents of similar nature while in our employ? Yes No

If YES please explain:

_____

_____

_____

_____

Is employee working now? Yes No **If Yes, at his/her normal job?** Yes No

Date of return / ¨termination ¨ (complete later if necessary): _____

Date and time reported: _____ 20 _____ at _____ A.M. / P.M.

Exact location on project: _____

Probability of recurrence: □ Rare □ Occasional □ Frequent

First Aid Treatment given (If applicable):

_____

_____

_____

_____

First aid attendant: _____ **Employed by:** _____

ACCIDENT INVESTIGATION REPORT

☐ DRAFT REPORT ☐ FINAL REPORT

Emergency Service Called	Phone	Time
Ambulance	**911**	
Police	**911**	
Fire	**911**	
Worksafe BC		
If yes name of Inspector:		
Was permission given to continue work?	**☐Yes ☐No**	*(Yes or No, by whom and what time)*

If employee has been seen by, or intends to see a doctor, indicate name, address and date of visit:

Property/Equipment damage incurred, nature, and cost (please indicate whether actual or estimate):

Job being performed at time of accident/incident:

Is there a written safe job procedure? Yes No **If yes, was it followed?** Yes No

Others involved and their employers:

ACCIDENT INVESTIGATION REPORT

☐ DRAFT REPORT ☐ FINAL REPORT

Witnesses and their employers:

Name	Employer

Describe exact events that preceded the accident/incident (attach sketch, photos or extra sheets as necessary): _____

Describe the factors that were the most direct cause of the accident/incident: _____

☐ DRAFT REPORT ☐ FINAL REPORT

Describe corrective actions to be taken / by whom / date to be implemented: _____

Investigation commenced: _____ 20 _____ at _____ A.M. / P.M.

Investigation completed: _____ 20 _____ at _____ A.M. / P.M.

Investigator(s): _____

Manager's Signature: _____

Investigator's Signature _____

Date: _____

Accident – Witness Statement

WITNESS REPORTS ARE TO BE COMPLETED BY ANY PERSON WHO WITNESSES AN INCIDENT, OR BY THOSE WHO HAVE ANY INFORMATION REGARDING AN ACCIDENT.

Date: _____ **Accident:** _____

Witness Name: _____

Address: _____

Phone: _____

Company Name: _____

Address: _____

Phone: _____

Witness Report:

If additional pages or sketches are required please use reverse side of form. Attach photos or other evidence.

I _____(witness) believe the information contained here and/or on the attached sheets signed by me to be a truthful representation of what I observed, felt, heard, sensed or smelled.

Witness Signature: _____ Investigator Signature: _____

Date: _____ Date: _____

Accident – Worker's Statement

Date: _____ **Accident:** _____

Worker's Name: _____

Address: _____

Phone: _____

Company Name: _____

Address: _____

Phone: _____

Worker's Report:

If additional pages or sketches are required please use reverse side of form. Attach photos or other evidence.

I _____(worker) believe the information contained here and/or on the attached sheets signed by me to be a truthful representation of what I observed, felt, heard, sensed or smelled.

Worker's Signature: _____ Investigator Signature: _____

Date: _____ Date: _____

ACCIDENT INVESTIGATION

Sketch Sheet

ACCIDENT INVESTIGATION

Photos