



TO BE USED FOR REPORTING ALL INCIDENTS / ISSUES INVOLVING PEOPLE OR PROPERTY

SECTION 1: INCIDENT / ISSUE TYPE  Injury  Volunteer Injury  Motor Vehicle Accident  Property Damage  Safety Concern  Near Miss

Other (Describe) \_\_\_\_\_ Does this incident involve a 3rd party person, vehicle or property? (Yes / No) \_\_\_\_\_

SECTION 2: DESCRIPTION OF INCIDENT / ISSUE Date \_\_\_\_\_ Time \_\_\_\_\_  a.m.  p.m.

Location/Address \_\_\_\_\_

Reported By \_\_\_\_\_ Emp # \_\_\_\_\_ Dept # \_\_\_\_\_

Is this the individual involved in the incident?  Yes  No

(Provide as much detail as possible, eg. who, what, why, where, when; and continue on Page 3 if necessary)

Large empty box for incident description.

Witness \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Additional Witness List Attached?  Yes  No

SECTION 3: INDIVIDUAL INVOLVED Name \_\_\_\_\_ Emp # \_\_\_\_\_ Dept # \_\_\_\_\_

Occupation \_\_\_\_\_ Hours of Work \_\_\_\_\_  a.m.  p.m. to \_\_\_\_\_  a.m.  p.m.

Employment Status  Full Time  Part Time  Temporary/Casual/Seasonal

Length of Service  < 1 year  1 - 5 years  6 - 10 years  11 - 15 years  16 - 20 years  > 20 years

Was the Employee  Working Alone  Working with Crew or Assigned Group Was the Supervisor on site?  Yes  No

Home Address \_\_\_\_\_ Ph # \_\_\_\_\_ Cell \_\_\_\_\_

Nature of Injury \_\_\_\_\_ Part of Body \_\_\_\_\_ Side of Body  Right  Left

Treatment  None  First Aid  Doctor/Hospital/Health Care Provider

Do you work a Compressed or Alternate work week? (Yes / No) \_\_\_\_\_

(NOTE: If Medical Practitioner seen or time loss, complete WCB Report @ ERC)

Transported to Hospital  Yes  No Name of First Aid Provider \_\_\_\_\_

SECTION 4: MOTOR VEHICLE ACCIDENT INFORMATION Vehicle # \_\_\_\_\_ of \_\_\_\_\_ COMPLETE THIS SECTION FOR EACH VEHICLE

If City Vehicle, Provide Unit # \_\_\_\_\_ and License Plate # \_\_\_\_\_ If 3rd Party Vehicle, Complete the following:

Name of Driver \_\_\_\_\_ Driver's License # \_\_\_\_\_ Expiry Date \_\_\_\_\_

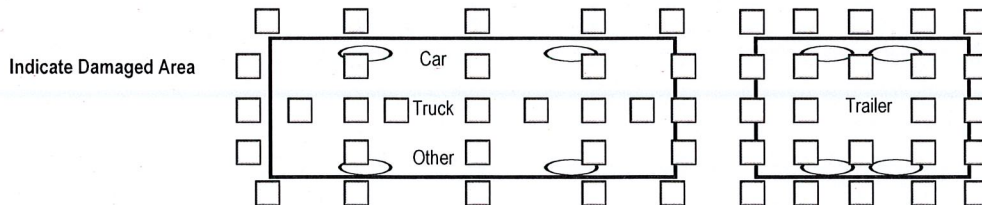
Vehicle Owner \_\_\_\_\_ Address \_\_\_\_\_ Ph # \_\_\_\_\_

License Plate # \_\_\_\_\_ Province \_\_\_\_\_ Make of Vehicle: Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Colour \_\_\_\_\_

VIN # \_\_\_\_\_ Insurance Company \_\_\_\_\_ Insurance Agent \_\_\_\_\_

Agent Address \_\_\_\_\_ Policy # \_\_\_\_\_ Expiry Date \_\_\_\_\_

Diagram of Accident Scene Attached?  Yes  No Photographs Attached?  Yes  No Police Report Attached?  Yes  No



NOTE: CITY VEHICLES MUST BE TAKEN TO FLEET FOR DAMAGE ASSESSMENT

Estimated City Vehicle Damage \_\_\_\_\_ Estimated 3rd Party Vehicle Damage \_\_\_\_\_ Speed of Travel \_\_\_\_\_ Km

Police Called?  Yes  No Attended?  Yes  No Fire/EMS Called?  Yes  No Attended?  Yes  No

Road Conditions:  1 Dry  2 Wet  3 Snow  4 Slush  5 Ice  6 Muddy  7 Loose Material  8 Other \_\_\_\_\_

Weather:  1 Clear  2 Rain  3 Hail/Sleet  4 Snow  5 Fog/Smoke  6 Dust  7 High Wind  8 Cloudy  9 Sunny

**SECTION 5: PROPERTY DAMAGE INFORMATION** (Supervisor to Complete Investigation Section)

City Property  Non-City/3rd Party Property Photographs Attached?  Yes  No Estimated Damage

To the best of my knowledge the information provided above is a factual and true account of the incident or issue being reported  Yes  No

**INCIDENT / ISSUE INVESTIGATION SECTION (to be completed by Supervisor)**

**PART 1: INVESTIGATION**

**A. INJURY INVESTIGATION (or N/A )**

**i) Incident Type:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 1 Struck By           | <input type="checkbox"/> 7 Caught Between              | <input type="checkbox"/> 13 Exposure to Blood/Body Fluid          |
| <input type="checkbox"/> 2 Struck Against      | <input type="checkbox"/> 8 Contact with Electricity    | <input type="checkbox"/> 14 Overexertion                          |
| <input type="checkbox"/> 3 Fall to Lower Level | <input type="checkbox"/> 9 Contact with Heat           | <input type="checkbox"/> 15 Physical Assault                      |
| <input type="checkbox"/> 4 Slip/Trip           | <input type="checkbox"/> 10 Contact with Cold          | <input type="checkbox"/> 16 Contact with a Sharp Edge             |
| <input type="checkbox"/> 5 Caught In           | <input type="checkbox"/> 11 Contact Hazardous Material | <input type="checkbox"/> 17 Contact with Needle                   |
| <input type="checkbox"/> 6 Caught On           | <input type="checkbox"/> 12 Noise Exposure             | <input type="checkbox"/> 18 Other (Describe) <input type="text"/> |

**ii) Source of Injury:**

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> 1 Hand Tool  | <input type="checkbox"/> 5 Animal/Insect | <input type="checkbox"/> 9 Floor/Sidewalk/Parking Lot             |
| <input type="checkbox"/> 2 Power Tool | <input type="checkbox"/> 6 Motor Vehicle | <input type="checkbox"/> 10 Elevated Working Surface              |
| <input type="checkbox"/> 3 Person     | <input type="checkbox"/> 7 Chemical      | <input type="checkbox"/> 11 Stairs/Ladder                         |
| <input type="checkbox"/> 4 Needle     | <input type="checkbox"/> 8 Moving Parts  | <input type="checkbox"/> 12 Other (Describe) <input type="text"/> |

**B. MOTOR VEHICLE ACCIDENT INVESTIGATION (or N/A )**

**i) Vehicle Accident Type:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 1 Struck Object | <input type="checkbox"/> 5 Head On                 | <input type="checkbox"/> 9 Sideswipe - Opposite Direction         |
| <input type="checkbox"/> 2 Off Road Left | <input type="checkbox"/> 6 Passing - Left Turn     | <input type="checkbox"/> 10 Rear End                              |
| <input type="checkbox"/> 3 Right Angle   | <input type="checkbox"/> 7 Left Turn - Across Path | <input type="checkbox"/> 11 Off Road Right                        |
| <input type="checkbox"/> 4 Backing       | <input type="checkbox"/> 8 Passing - Right Turn    | <input type="checkbox"/> 12 Sideswipe - Same Direction            |
|  |  | <input type="checkbox"/> 13 Other (Describe) <input type="text"/> |

**PART 2: ROOT CAUSES (choose all that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> 1 Lack of Training   | <input type="checkbox"/> 8 Mind Not on Task               | <input type="checkbox"/> 15 Inadequate Supervision                     |
| <input type="checkbox"/> 2 Lack of Experience | <input type="checkbox"/> 9 In Line of Fire                | <input type="checkbox"/> 16 Failure to Follow Safe Work Practice/Rules |
| <input type="checkbox"/> 3 Rushing            | <input type="checkbox"/> 10 Balance/Traction/Grip         | <input type="checkbox"/> 17 Tools/Equipment/Materials/Workstation      |
| <input type="checkbox"/> 4 Frustration        | <input type="checkbox"/> 11 Failure to Wear PPE           | <input type="checkbox"/> 18 Inadequate Maintenance                     |
| <input type="checkbox"/> 5 Fatigue            | <input type="checkbox"/> 12 Improper Lifting              | <input type="checkbox"/> 19 Inadequate Policy/Safe Work Practice       |
| <input type="checkbox"/> 6 Complacency        | <input type="checkbox"/> 13 Failure to Ask for Help       | <input type="checkbox"/> 20 Failure to Obey Traffic Law(s)             |
| <input type="checkbox"/> 7 Eyes Not on Task   | <input type="checkbox"/> 14 Failure to Use Lifting Device | <input type="checkbox"/> 21 Fail to Pre-Check                          |
|   |   | <input type="checkbox"/> 22 Other (Describe) <input type="text"/>      |

**PART 3: CORRECTIVE ACTION (to prevent recurrence)**

Supervisor  Date  Manager  Date

All Employee/Volunteer Workplace INJURIES: **Submit Online to ERC** ... or FAX IMMEDIATELY to EMPLOYEE RESOURCE CENTRE 403-320-2823

All OTHER Incident/Accident Issues: **Submit Online to IRM** ... 300 Corporate Safety Incidents Mailbox: irmincidents@lethbridge.ca

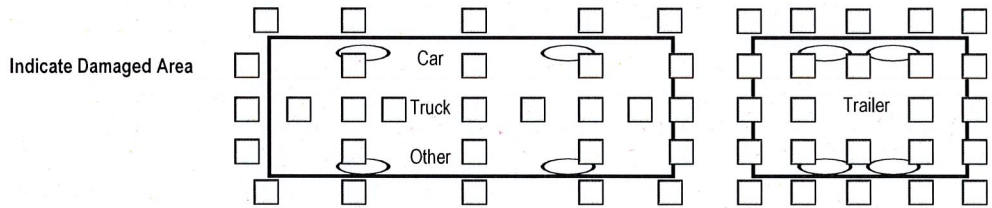
The personal information requested on this form is being collected for the purpose of obtaining factual information pertaining to an incident or issue, and is being collected under the authority of the Freedom of Information and Protection of Privacy Act and may be disclosed to interested parties for the purpose of follow-up, investigation or litigation. If you have any questions about the collection, use or disclosure, contact Melissa Craig, Corporate Health and Safety Manager, 910-4th Avenue South, Lethbridge, AB, T1J 0P6 or call (403) 320-3915.

Large empty rectangular box for incident description.

SECTION 4: MOTOR VEHICLE ACCIDENT INFORMATION Vehicle # [ ] of [ ]

Form fields for vehicle and driver information: Name of Driver, Vehicle Owner, License Plate #, VIN #, Agent Address, etc.

Diagram of Accident Scene Attached? [ ] Yes [ ] No Photographs Attached? [ ] Yes [ ] No Police Report Attached? [ ] Yes [ ] No



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