WORKPLACE INCIDENT REPORT (WIR) - To be completed by the Management Supervisor

Health, Safety & Employee Well-Being (HSEWB), Kinsmen Building, York University
Email: wir@yorku.ca **Or Fax: 416 - 736 - 5439**

- ***Please complete and submit to HSEWB within 24 hours with all the attachments. (wir@yorku.ca)***
- ***For reporting purpose, submit immediately even if any of the signatures are missing. Obtain necessary signatures later and re-submit.***

Injury/Incident Type (check box):	Definition:	Sections to Complete:
☐ First Aid	Employee suffered a minor injury/illness and may have required First Aid (e.g. band aid, ice etc.); however, did not require medical attention from a health care practitioner and **did not** miss any time from work **after the date of the incident**.	Sections A, B C, F, I, J, K, L and Distribution
☐Health Care	Employee received medical attention from a health care practitioner (e.g. physician, physiotherapist etc.) **WITHOUT** any missed time from work beyond the date of incident.	All Sections including Distribution except E, and H
☐ Lost Time	Employee is absent from work for their next scheduled shift **after the date of the incident** due to the injury or illness, including any missed time for appointments **after the date of the incident.**	All Sections including Distribution (note: Section H may not be applicable)
☐ Recurrence	Incident is indicated as related to a previous WSIB claim. For more information, please contact HSEWB at wir@yorku.ca**.**	Sections A, B, D, H, I, J, K, L, and Distribution
☐ Near Miss/Incident	Incident without resulting in an injury/illness (e.g. a ceiling panel fell but did not strike anyone and did not cause any injury).	Sections A, B C, I, J, K, L and Distribution
☐ Property Damage	Incident that resulted in damage to York University's property (e.g. facilities, equipment, vehicles and etc.).	Sections A, B C, I, J, K, L and Distribution
☐ Critical Injury (**including fatality**)	As per Regulation 834 **Note: Immediately contact HSEWB: 416 -736-5491. If after hours or unable to reach assigned area Health and Safety Advisor, voicemail provides contact information for On-Call Health and Safety personnel.**	All Sections including Distribution (note: Section H may not be applicable)

SECTION A. Employee Personal Information			
Last Name:		First Name:	
Pay rate (**if hourly**):	**per hour**		
Employee #:		Job Title:	
Department Name:		Department Location:	
Primary phone #:		Work Phone #:	
Email Address:		Union Affiliation (if applicable):	

SECTION B. Management Supervisor Information			
Last Name:		First Name:	
Email Address:		Work Phone #:	

SECTION C. Incident Details

1. Date and time of incident/illness, **OR** incident/illness awareness by the employee	dd	mm	yy	*Hour*	*Minutes*	☐ **AM** ☐ **PM**	3. Who was the incident/illness reported to?
2. Date and time reported to employer (management supervisor)	dd	mm	yy	*Hour*	*Minutes*	☐ **AM** ☐ **PM**	Name: Title:

4. If delay in employee reporting, explain reason:

5. Was the employee performing their regular position or alternate position at the time of injury? ☐ **Regular** ☐ **Alternate Job Position**

6. Type of the incident/illness:
☐ Sudden specific event/occurrence
☐ Gradually occurring over time
☐ Occupational disease (explain): _____
☐ Fatality

7. Nature of incident/illness (check all that apply):
☐ Slip ☐ Fall ☐ Trip ☐ Struck/Caught
☐ Repetition ☐ Overexertion ☐ Harmful Substances/Environmental
☐ Traumatic Incident ☐ Motor Vehicle Incident
☐ Fire/Explosion ☐ Assault
☐ Other: _____

8. Area of Injury / body parts (check all that apply):

☐ Head	☐ Neck	☐ Upper Back	**L**		**R**	**L**		**R**	**L**		**R**	**L**		**R**
☐ Face	☐ Chest	☐ Lower Back	☐	Shoulder	☐	☐	Wrist	☐	☐	Thigh	☐	☐	Foot	☐
☐ Teeth	☐ Abdomen	☐ Pelvis	☐	Upper Arm	☐	☐	Hand	☐	☐	Knee	☐	☐	Toe(s)	☐
☐ Other:			☐	Elbow	☐	☐	Finger(s)	☐	☐	Lower Leg	☐	☐	Eye(s)	☐
			☐	Forearm	☐	☐	Hip	☐	☐	Ankle	☐	☐	Ear(s)	☐

9. Dominant Hand: ☐ Right handed ☐ Left handed ☐ Ambidextrous ☐ Unknown

10.1 Describe what happened to cause the incident/illness (e.g. tripped on a cord, struck by a tool):

10.2 Describe the specific task that the employee was performing at the time of the incident/illness (e.g. mopping the floor):

10.3 Was 10.2 (above) one of the employee's regular tasks? ☐ Yes ☐ No → Why was the employee performing this task? **Explain below**:

10.4 Describe what type of First Aid was provided (if any) and by whom:

Name: Job Title: Work phone #:

11. Did the incident/illness happen on York University's premises (owned, leased or maintained)? ☐ **Yes** ☐ **No**

12. Where did the incident/illness occur?
Location (**building, room#, campus**):

13. Did the incident/illness happen outside the province of Ontario? ☐ **Yes** ☐ **No**
→**If yes**, specify location (city, province, state, country):

14. List all employees or other persons **involved in** incident/illness, their positions and contact information:
Name: Job Title: Work phone #:

Name: Job Title: Work phone #:
****If there are more than 2 persons involved, attach a separate sheet.**

15. Are you aware of any **witnesses** for this incident/illness? ☐ **Yes** ☐ **No** ☐ **Unknown**
→**If yes,** provide:
Name: Job Title: Work phone #:

Name: Job Title: Work phone #:
****If there are more than 2 persons involved, attach a separate sheet.**

16. Was anyone who was not working for York University either partially or fully responsible for this incident/illness? ☐ **Yes** ☐ **No**
→**If yes,** provide:
Name: Job Title: Work phone #:

Name: Job Title: Work phone #:
****If there are more than 2 persons involved, attach a separate sheet.**

17. Are you aware of any prior similar or related problem, injury or condition? ☐ **Yes** ☐ **No**
→ **If yes**, explain:

18. Do you have any concerns about this incident/illness? ☐ **Yes** ☐ **No** → If yes, explain:

***If needed, provide a separate document outlining concerns.**

SECTION D. Health Care

1. Did the employee receive Health Care due to this injury/illness (as per Health Care description on Page 1)? ☐ **Yes** ☐ **No** ☐ **Unknown**

2. Date first Health Care sought:	dd	mm	yy	3. When did you learn that the employee received Health Care?	dd	mm	yy

4. Where was the employee treated for this injury/illness? (Check all that apply)
☐ Clinic ☐ Health Care Professional's office ☐ Emergency department ☐ Admitted to hospital ☐ Ambulance
☐ Other:

5. Contact information of the Health Care Professional or Medical Facility who treated this employee (if known):
Health Care Professional/ Medical Facility Name:
Address: Phone #:

SECTION E. Lost Time

1. **After the day of the incident/illness,** this employee:
☐ Returned to their regular duties and has not lost any time and/or earnings
☐ Returned to modified duties and has not lost any time and/or earnings
☐ Has lost time and/or earnings after the date of incident/illness →**If so, COMPLETE 1.1 and 1.2**

1.1 Date employee first lost time:	dd	mm	yy	1.2 Expected return to work date (if known): ☐ Regular ☐ Modified	dd	mm	yy

2. Date and hour last employee worked:	dd	mm	yy	Hour	Minutes	☐ AM ☐ PM

3. **Normal** working hours on last day worked:	From Hour	From Minutes	☐ AM ☐ PM	To Hour	To Minutes	☐ AM ☐ PM

SECTION F: Return to Work/Modified Work

1. Should you receive any of the following documents, forward to wir@yorku.ca, Fax: 416-736-5439:
- ❖ Page 2 of WSIB Form 8
- ❖ Functional Abilities Form (FAF)
- ❖ Doctor's notes/correspondence

2. Are there modified duties available for this employee?
☐ Yes ☐ No

3. Were modified duties offered to employee? ☐ Yes* ☐ No
***Attach a copy of the modified work offer (e.g. email to employee, letter etc.)**

4. Did the employee accept the modified duties? ☐ **Accepted** ☐ **Declined**

SECTION G: Other Required Information

1. Current # of accumulated sick credits: _____ (**Days)**

2. Hours worked per week (**if not full-time**, please provide the hours of work for the 4 weeks prior to date of injury under Item C):

☐ **A. Regular Schedule** – Indicate normal work days and hours (excluding unpaid lunch or break)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Example:

S	M	T	W	T	F	S
	8	8	8	8	8	

Or,

☐ **B. Repeating Rotational Shift** - (Example**:** 4 days on, 4 days off, 12 hours per shift, 8 weeks in cycle.)

# of days on		# of days off		Hours per shift(s)		# of weeks in cycle	

Or,

☐ **C. Varied or Irregular Work Schedule** – Provide the total # of regular hours and shifts for each week for the 4 weeks prior to the incident/illness (excluding unpaid lunch/breaks):

	Week 1	Week 2	Week 3	Week 4
From/to date (dd/mm/yy)	/	/	/	/
Total hours worked				
Total shifts worked				

Or,
☐ **D. Other** - If none of the above applies, please specify the work schedule below:

3. Has the employee worked/earned: Overtime, Vacation Pay, Shift Premium or any other premium pay in the **last 4 weeks** prior to the injury/illness? ☐ **Yes** ☐ **No** → If yes, please specify: _____

Section H: Recurrence (complete this section only in case of a recurrence)

1. Date of original incident:	dd	mm	yy	2. Date of recurrence:	dd	mm	yy

2. Describe the circumstances of the recurrence of disability as reported by the employee. If the condition gradually worsened over time, describe the progress of the condition and complaints from the time of original injury/illness up to the date of recurrence.

3. Did the employee report or discuss any ongoing problems with management supervisor and/or colleagues at work about this condition?
☐ No ☐ Yes, provide details in the space provided:

4. Did the employee become absent/missed time from work or required modified duties after the original incident?
☐ No ☐ Yes, provide details in the space provided:

5. Are you aware of any factors or other problems aside from the original work incident which may have contributed to the employee's present reoccurrence? ☐ No ☐ Yes, provide details in the space provided:

Section I: Potential Causal and/or Contributing Factors (PEMEP)

1. PEOPLE

a) Were there any personal factors that may have contributed to the incident/injury/illness (e.g. actions taken or not taken)?
☐ No ☐ Yes, provide details in the space provided: _____

2. EQUIPMENT/VEHICLE/APPARATUS

a) Was any vehicle/equipment/apparatus involved in this incident/injury/illness?
☐ No ☐ Yes →**If yes, how**? _____
b) Provide the type of vehicle/equipment/apparatus: _____
c) Vehicle/equipment/apparatus number: _____
d) When was the vehicle/equipment/apparatus last inspected? Date: _____
e) Was the employee trained to use/operate vehicle/equipment/apparatus? ☐ No ☐ Yes
→**If yes, provide date last trained (if available): _____**

3. MATERIALS

a) Was the use of chemicals/products involved in this incident/injury/illness? ☐ Yes ☐ No ☐ Unknown
→If yes, provide details: _____
b) Name of the chemical/product (attach copy of chemical MSDS/SDS): _____
c) Was the product labeled? ☐ Yes ☐ No
d) Was the employee trained in the use of this chemical/product? ☐ No ☐ Yes → If yes, provide date last trained: _____ (dd/mm/yy)
e) Did handling of material/an item (e.g. boxes) contribute to the incident/injury/illness?
☐ No ☐ Yes → If yes, provide details: _____
f) Item handled: _____
g) Description of item (e.g. weight in kg/lb, size/dimensions): _____

4. ENVIRONMENT

a) Describe the environment at the time of the incident/injury/illness (e.g. weather, surface type):

5. PROCESS

a) Are there any available written procedures and/or SOPs outlining how the task should be performed? ☐ Yes ☐ No
→If yes, has the employee been trained on this procedure and/or SOP? ☐ Yes ☐ No
→If no, should procedures and/or SOPs for this task be developed? ☐ Yes ☐ No

b) Were appropriate Personal Protective Equipment (PPE) such as footwear worn for the task/job activity?
☐ Yes ☐ No ☐ Not applicable →If yes, indicate type:

c) What was the condition of the PPE? ☐ Excellent ☐ Good ☐ Poor

Section J: Corrective Action

1. Was an immediate corrective action(s) taken? ☐ Yes ☐ No ☐ Not applicable
→If yes, provide details:

→Provide completion date of immediate corrective action(s): _____
(dd/mm/yy)

2. What other preventative action(s) will be taken to ensure a future incident/injury/illness of this type does not occur?

→Provide target completion date for the preventative action(s): _____
(dd/mm/yy)

3. Is follow-up investigation required? (to be completed by the next level management or delegate) ☐ Yes ☐ No

Section K: Signatures (**Note:** All information is collected by York University pursuant to and in compliance with the Workplace Safety and Insurance Act, the Occupational Health and Safety Act, and the Freedom of Information and Protection of Privacy Act and all regulations enacted thereunder, in effect from time to time, in addition to any other relevant laws and regulations as may be applicable. York University shall treat all information as sensitive and confidential and shall only use and disclose such information in accordance with or where required by law.)

Management Supervisor Name (PRINT):	**Signature:**	**Title:**	**Date (dd/mm/yy):**	**Phone #:**
Employee Name (PRINT), if possible:	**Signature:**	**Date (dd/mm/yy):**		**Phone #:**

Section L: Joint Health and Safety Committee (JHSC)

The following section is provided for the investigating worker member of the applicable JHSC to provide any additional comments, if necessary. This may include findings of the worker's investigation (if different from those of the management supervisor), as well as recommendations for correcting the hazard and preventing future occurrences.

****FOR COMPLETION BY JHSC MEMBER ONLY**
☐ **No comments (check if applicable)**

JHSC Member Name (PRINT):	
JHSC Name:	
Signature:	
Date (dd/mm/yy):	
Phone #:	

To locate the applicable JHSC Worker Member, please visit the JHSC website and choose the applicable JHSC.

Distribution:

- Management Supervisor will provide a copy within 24 hours to: Employee, applicable JHSC member (*mandatory - fill in name below), and area Health and Safety Officer (HSO)
  ***JHSC Member Name**: _____ and ***JHSC Name:** _____
- Management Supervisor must retain the original WIR copy for record keeping purposes

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