



# UBC FACULTY & STAFF INCIDENT / ACCIDENT REPORT

This form is to be completed by the worker's supervisor.

- 1) Fax page 1 (YELLOW) including the Worker's Report of Injury to Employer (WCB Form 6A) and First Aid Report (Form 7A) to Health, Safety & Environment (HSE) at 604-822-0572 within 24 hours of injury.
- 2) Complete page 2 (BLUE) within 3 working days after the incident has been reported.  
Do **NOT** distribute page 1 (YELLOW) as it contains confidential information that must be collected to initiate a WCB claim.  
For more information contact the HSE Claims Assistant 604-822-8759.

<b>1</b>	<b>Was the Accident:</b> <input type="checkbox"/> No medical treatment, no time loss – complete only sections 1, 2 (employee's name, union and crew number only) and 4. <input type="checkbox"/> Medical treatment (visit doctor, no days off work) – complete sections 1, 2 and 4. (Include Employee's Report Form 6A.) <input type="checkbox"/> Time Loss (days off work) – complete sections 1, 2, 3 and 4. (Include Employee's Report Form 6A.)						
Date & Time of Incident/Accident: (y/m/d) _____ AM _____ PM		<b>OR</b>	Period of Exposure Resulting in Industrial Disease (y/m/d) From: _____ To: _____		Location of Accident (Bldg, Rm #)		
Name of Person First Reported to:		Date and Time Reported: (y/m/d) _____ AM _____ PM		Supervisor of worker involved: Phone # _____ Email: _____		Date and Time Reported: (y/m/d) _____ AM _____ PM	
Worker's Department		Worker's Job Title		Was First Aid Given? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES - is First Aid Report included: <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of First Aid Attendant	
Describe fully what happened. If more space is required, attach an additional page. Attach additional information, diagrams or photos where possible.							
Describe the injury in detail. What body part was injured? (i.e. sprained left ankle, broken right wrist)							Body Part Injured: <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> Right
<b>2</b>	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Employee's Name (Family/Given)		Union/Association		Crew #
Worker's Home Address:		Street Name/No.			Town/City		Postal Code
Telephone Number (Area Code & Number)		Social Insurance Number		Birthdate (y/m/d)	Age (Yrs)	BC Care Card No.	
Date Joined UBC (y/m/d)	Started Current Position (y/m/d)	Employment Status: <input type="checkbox"/> Full time, on-going <input type="checkbox"/> Temporary <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Casual <input type="checkbox"/> Other _____		Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg		Height: <input type="checkbox"/> in <input type="checkbox"/> cm	
Name of Doctor or Hospital Visited		Doctor or Hospital Address:					
Name of Witness(es)		Address / Phone #				Do witnesses confirm worker's statement?	
1.						<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.							
Were the worker's actions at the time of injury for the purpose of the University's business? <input type="checkbox"/> Yes <input type="checkbox"/> No, If no, explain							
Were the activities part of the worker's regular work? <input type="checkbox"/> Yes <input type="checkbox"/> No, If no, explain							
Is there any reason to feel that the injury did not occur as stated? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, explain							
Are you aware of any previous pain or disability in the area of the present injury? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, explain							
Was any person not employed by UBC responsible for the injury? <input type="checkbox"/> No <input type="checkbox"/> Yes, Give details, name & address of person.							
<b>3</b>	Wage information of injured worker <i>(If NO time loss, skip this section and go to Sec. 4)</i>			Worker's Exact Gross Wage (provide one only) Hourly Employee: \$ _____ / hour		Additions to wages (provide details) (i.e. shift premiums, holiday pay, meals)	
Show normal work week by entering hours worked per day.			Monthly Employee: \$ _____ / month				
	S	M	T	W	T	F	S
Wk #1							
Wk #2							
Date and time last worked after injury: (y/m/d) _____ AM _____ PM		Normal Work Hours: From: _____ To: _____		Number of days in Sick bank:			
Does the worker work a fixed shift rotation? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe:		Shift Start Date: (y/m/d)		Has Employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		If employee has returned to work - when? (y/m/d)	
<b>THE FIRST PAGE IS CONFIDENTIAL AND IS ONLY COLLECTED BY HSE TO INITIATE A WCB CLAIM AS REQUIRED BY LAW. DO NOT DISTRIBUTE SECTIONS 2 &amp; 3 OTHER THAN TO HEALTH, SAFETY AND ENVIRONMENT.</b>							
Date Report Completed (y/m/d)			Supervisor's Signature			Supervisor's Name (Please Print)	



# UBC FACULTY & STAFF INCIDENT / ACCIDENT REPORT

The incident/accident must be investigated by the worker's supervisor and a worker member of the Local Safety Committee within 3 working days of the incident or accident. Complete this page and distribute as follows:

- 1) Fax a copy to Health, Safety & Environment 604-822-0572
- 2) Send the original to the Department Head
- 3) Send a copy to the local Safety Committee;
- 4) Post a copy at the work site.

<b>1</b>	<b>Was the Accident:</b> <input type="checkbox"/> No medical treatment, no time loss – complete only sections 1, 2 (employee's name only) and 4. <input type="checkbox"/> Medical treatment (visit doctor, no days off work) – complete sections 1, 2 and 4. (Include Employee's Report Form 6A.) <input type="checkbox"/> Time Loss (days off work) – complete sections 1, 2, 3 and 4. (Include Employee's Report Form 6A.)		
Date & Time of Incident/Accident: (y/m/d) _____ AM _____ PM		<b>OR</b>	Period of Exposure Resulting in Industrial Disease From: (y/m/d) _____ To: _____
Location of Accident (Bldg, Rm #)			
Name of Person First Reported to:	Date and Time Reported: (y/m/d) _____ AM _____ PM	Supervisor of worker involved: Email: _____ Phone # _____	Date and Time Reported: (y/m/d) _____ AM _____ PM
Worker's Department	Worker's Job Title	Was First Aid Given? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES - is First Aid Report included: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of First Aid Attendant
Describe fully what happened. If more space is required, attach an additional page. Attach additional information, diagrams or photos where possible.			
Describe the injury in detail. What body part was injured? (i.e. sprained left ankle, broken right wrist)			Body Part Injured: <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> Right
<b>4 Accident Investigation</b> (use reverse of page if more space is required)			Was the accident site visited? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Select one or more causes from each category</b>			
<b>Task</b>	<b>Environment</b>	<b>Equipment</b>	
<input type="checkbox"/> Lifting <input type="checkbox"/> Twisting the trunk <input type="checkbox"/> Lifting overhead <input type="checkbox"/> Heavy load - Lift <input type="checkbox"/> Heavy load - Push <input type="checkbox"/> Heavy load - Pull <input type="checkbox"/> Awkward load to handle <input type="checkbox"/> Hot load <input type="checkbox"/> Sharp edges on load <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Stooping <input type="checkbox"/> Extended reach <input type="checkbox"/> Incorrect tool <input type="checkbox"/> Rushing <input type="checkbox"/> Procedures not followed <input type="checkbox"/> No "Task" factors <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Limited space / constrained posture <input type="checkbox"/> Housekeeping <input type="checkbox"/> Variations in floor surface <input type="checkbox"/> Cold / Hot <input type="checkbox"/> Wet / slippery <input type="checkbox"/> Vision obstructed <input type="checkbox"/> Personal Protective Equipment restrictions <input type="checkbox"/> No "Environment" factors <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Incorrect equipment <input type="checkbox"/> Defective equipment <input type="checkbox"/> High force requirement <input type="checkbox"/> Preventative maintenance inadequate <input type="checkbox"/> Signage / labeling inadequate <input type="checkbox"/> Material / equipment failure <input type="checkbox"/> Equipment vibration <input type="checkbox"/> No "Equipment" factors <input type="checkbox"/> Other (Specify) _____	
	<b>Organizational</b>	<b>Human</b>	
	<input type="checkbox"/> Poor Communication <input type="checkbox"/> Excessive workload <input type="checkbox"/> Job / skill training inadequate <input type="checkbox"/> Planning inadequate <input type="checkbox"/> Staffing inadequate <input type="checkbox"/> Poor job design <input type="checkbox"/> No Standard Operating Procedure available <input type="checkbox"/> No "Organizational" factors <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Fatigue <input type="checkbox"/> Illness <input type="checkbox"/> Knowledge / skill / experience lacking <input type="checkbox"/> Language difficulties <input type="checkbox"/> Personal distraction <input type="checkbox"/> Physical limitations <input type="checkbox"/> Pre-existing condition <input type="checkbox"/> No "Human" factors <input type="checkbox"/> Other (Specify) _____	
Incorporating the above factors, describe the cause of the accident:			
Describe the recommended corrective actions to be implemented to prevent recurrence. These actions should encompass all workers facing similar risks.			
Person(s) responsible for planned corrective actions		Date to complete corrective actions: (y/m/d)	
Supervisor (Please print)		Safety Committee Member (Please print)	Date form completed: (y/m/d)



# UBC FACULTY & STAFF INCIDENT / ACCIDENT REPORT

## INSTRUCTIONS

### SECTION 1 - Description of Event

This section is to be completed for **all** incidents/accidents.

#### Was the Accident:

(This section is very important as it determines what other sections may need to be completed)

- Note:** For accidents that:
- resulted in serious injury or death;
  - involved an explosion, major structural failure;
  - involved the major release of a hazardous substance; or,
  - involved a diving accident.

**Immediately** notify 9-1-1 and HSE at 604-822-2029.

#### No Medical Treatment, No Time Loss:

The employee did not seek medical attention other than first aid and did not take time off work past the date of injury. Include incidents with the potential for injury.

#### Medical Treatment:

The employee visited a doctor or received medical treatment, but did not take any time off work past the date of injury.

#### Time Loss:

The employee needed time off work past the date of injury. In this case, the employee must seek medical treatment.

All incidents/accidents that involve Medical Treatment (other than first aid) or Time Loss will be reported to WCB.

#### Date & Time of Incident/Accident OR Period of Exposure Resulting in Industrial Disease:

Complete one **OR** the other, not both. If you do not know the date, write "worker alleges" or "unknown". For repetitive strain or accumulative conditions, note the date that the pain was first felt and indicate to "present", unless the pain has ceased.

#### Location of Accident:

List both the building name and the room number. If outside, describe the location as precisely as possible.

#### Was First Aid Given?

If First Aid completed, please include with report.

#### Describe fully what happened:

Describe the incident/accident including as many details as possible, such as the approximate weight of the objects involved and the frequency or length of the activity. Attach an additional page if more space is required. **Do not include any names in this section. Refer to the injured worker as "the worker" or "the employee".**

### SECTION 2 - Personal Information of Injured Worker

This section is to be completed only if the employee sought medical attention (other than first aid) or has missed time from work. Personal information is required by WCB. Please complete all sections as directed.

#### Name of Doctor or Hospital Visited:

Complete if known. **Note: An employee must seek medical attention to file a WCB Claim.**

#### Name of Witness(es):

List people who actually SAW the injury take place as well as a contact phone number for each. For example, someone who had his/her back turned toward the employee as the injury happens is not considered a witness.

#### Do witnesses confirm worker's statement?

If you have not interviewed the witness, please write in "unknown" or "not interviewed".

### SECTION 3 - Wage Information of Injured Worker

Complete Section 3 if the employee missed time from work due to injury.

#### Show normal workweek:

Please indicate the number of hours each day the employee works each day. If employee works a fixed schedule, only one week needs to be shown. If the employee's work hours vary from week to week (i.e. casual or student employees) please indicate the shifts worked in the two weeks prior to the date of injury.

Example of a fixed work schedule

	S	M	T	W	T	F	S
Wk #1		5	5	5	5	5	
Wk #2							

Example of a variable work schedule

	S	M	T	W	T	F	S
Wk #1	-	7	7	7	-	7	7
Wk #2	7	7	-	7	7	7	-

#### Does the worker work a fixed shift rotation?

**An example of a shift rotation is an 8-day cycle - 2 days, 2 nights, 4 days off. Please describe shift rotation and the start date of the cycle that the employee was in when the injury occurred.**

#### Worker's exact gross wage:

Provide the exact wage (no estimates). For hourly employees, indicate only the wage/hour only. For monthly paid employees, indicate the gross monthly wage.

#### Date and time last worked after injury:

This is usually the same as the date and time of the injury if the employee leaves work immediately. If the employee works beyond the injury date or time, please indicate the first absence following the injury. This information may need to be provided to WCB claims assistant after the initial report has been submitted. Please fax an amended form with the appropriate time loss information to HSE when it becomes available.

#### Has employee returned to work?

Please provide date or estimated date if known.

#### Additions to wages:

Describe any shift premiums, i.e., amount paid, what time it applies (full or partial shift).

#### Normal work hours:

Give the regularly scheduled shift, i.e. 7:30am to 3:30pm.

#### Number of days in sick bank:

If the exact number is unknown, please provide an estimate.

