

Incident Report and Investigation Form Steps to Incident Reporting

Step 1: Reporting

- The injured employee or student/volunteer reports to the first aid attendant for first aid treatment, as soon as possible.
- The affected employee reports the incident to their immediate supervisor as soon as possible.
- If the incident involves violence in the workplace, the incident is reported immediately by the supervisor to the Director of Human Resources and the District Health and Safety Officer. If involving a student with Special Needs, contact the Director of Student Services.
- Complete all necessary forms.

Step 2: First Aid Responsibilities—The first aid attendant completes the “*WorkSafeBC Form 7A—First Aid Report*” for any first aid treatment provided to the injured employee.

The first aid attendant records any first aid treatment to a student or volunteer into the first aid log book and completes the *Incident Report form from the Schools Protection Program Risk Management* for any injured student (See Item #2 of Regulation 3041 MR2).

Step 3: Employee Responsibilities—If fit to do so, the injured employee completes the school district’s *Incident Report and Investigation Form Employee Report Section*.

If fit to do so, the injured employee completes “*WorkSafeBC Form 6A—Worker’s Report of Injury or Occupational Disease to Employer*”, page 4 of this report. **NOTE:** Form 6A should not be completed by anyone else for signature by the injured worker.

Step 4: Site Based Team Responsibilities—The **Investigative Section** of the *Incident Report and Investigation Form* is to be completed by the investigating team comprising of the immediate site supervisor or administrator, the employee and a worker representative.

Should the incident involve violence in the workplace, a risk assessment is completed by the site based committee and if necessary, a staff safety plan is to be developed as part of the investigation section of the Incident Report and Investigation Form.

Step 5: Supervisor Responsibilities—The supervisor of the building completes “*WorkSafeBC Form 7—Employer’s Report of Injury or Occupational Disease*” for any staff injured on their site, where medical attention is required.

- Violence in the workplace incident requires a risk assessment to be undertaken and, if necessary, staff safety plans developed as per management regulation 3043MR1 and filed with appropriate parties.
- The site supervisor photocopies all forms to retain and distributes copies as necessary to required parties and notes action and communication taken, and sends originals of all forms to the District Health and Safety Officer.
- **All forms are required to be completed and submitted to the District Health and Safety Officer within 24-hours of the incident.**
- After being checked for completeness, the School District’s Health and Safety Officer will forward all required documentation to the *WorkSafeBC* office.

SCHOOL DISTRICT NO. 71 (COMOX VALLEY)
Management Regulation 3041 MR2

INCIDENT REPORT and INVESTIGATION FORM

EMPLOYEE REPORT SECTION: To be completed by the employee and reported to immediate supervisor. PLEASE PRINT

Name: _____ Location of Incident: _____

Position: _____ Employee #: _____ Date & Time of Incident: _____ at _____ am/pm

Date & Time Incident Reported: _____ at _____ am/pm

Name of Witness(es): _____

TYPE OF INCIDENT: Accident Unsafe Condition Air Quality Physical Violence/Verbal Abuse
 Other Vehicle Injury Property Damage
 Hazardous Material Near Miss

If it is a "violence in the workplace" incident affecting an employee, the supervisor immediately advises the Director, Human Resources and District Health and Safety Officer (Reference Policy 3043, Regulation 3043 MR1 and the Violence in the Workplace Program.) If involving a student with Special Needs, contact the Director of Student Services.

INVOLVEMENT WITH: Student (Student #: _____)
 Employee Public Other

Description or explanation of incident: _____

INJURY DETAILS: If there was an injury or health concern, please describe: _____

Employee is to fill out *WorkSafeBC* Form 6A, (Workers Report of Injury or Occupational Disease to Employer on back cover).

FIRST AID SECTION

- | | | | |
|----|------------------------------------|------------------------------|-----------------------------|
| 1. | Was First Aid required? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. | Was medical attention required? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. | Do you expect time away from work? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

First Aid Attendant to fill out the First Aid Report, Form 7A and attach if employee required first aid.

INVESTIGATION SECTION: To be completed by the site-based investigator(s). PLEASE PRINT

Name(s) of investigator(s): _____

and _____ and _____

Site Supervisor: _____ Safety Representative(s): _____

_____ Date of Investigation: _____

Description or Explanation of Incident _____

Apparent Cause: (Attach investigation documents as backup to cause)

Recommended corrective measures and action by specific date: _____

Police Notified: YES File Number: _____ NO

Name of Investigating Officer(s): _____

Risk Assessment Required: YES NO

Risk Assessment Completed: YES Not Required

Attach Staff Safety Plan

Date investigation was completed: _____

Signature of Investigator(s): _____ and _____

and _____

If medical attention required, Site Supervisor to fill out Form 7, Employer's Report of Injury or Occupational Disease and attach with this report.

COMMUNICATION OF ACTION. Site Supervisor forwards copies of reports and attachments as noted below.

Report copied to: Student File CUPE 439 At-risk Employee CDTA
 Site File Human Resources Student Services Administration

Which follow-up action required as follows:

1. Reports to be reviewed by site-based safety committee YES
2. Staff Safety Plan Completed and Reviewed YES NO Not Required
3. Parent/Guardian Notified YES NO
4. Staff Informed YES NO

Supervisor provides originals of all forms to the District Health and Safety Officer, c/o the School Board Office.

WORKER'S REPORT OF INJURY OR OCCUPATIONAL DISEASE TO EMPLOYER

Please answer all questions and complete this report in ink. Incomplete applications may have to be returned resulting in some delay in the processing of your claim. Please ensure that this report is signed and submitted by mail or fax. You may also wish to use the reverse side of this report or submit a separate letter.

This report should be completed by the injured worker if fit to do so. It should never be completed by anyone else for signature by the injured worker.

Section 53(3) of the *Workers Compensation Act* requires that where a worker is fit, and on a request of the employer, they must provide the employer with particulars of the injury or occupational disease on a report prescribed by the Board and supplied to the worker by the employer. This is the report prescribed.

Please complete this report as it appears. It is prohibited and an offence to add any questions to this report.

If you do not know the answers to any of the following questions, please print "don't know" in the appropriate space.

WORKER'S LAST NAME (please print) Mr. Ms. Mrs. Miss		EMPLOYER'S NAME (as registered with the Board)	
First name(s)	Middle initial	Mailing address	
Mailing address		City	Postal code
City	Postal code	Location of plant or project where injury occurred	Postal code
Telephone number	Social insurance number	Date of birth Month Day Year	Type of business
Weight	Height Feet Inches	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	Worker's occupation Employer's telephone number
1. Date and time of my injury 20 at a.m./p.m.		OR period of exposure resulting in my occupational disease: FROM 20 TO 20	
2. My injury or disease was first reported to my employer on 20 at a.m./p.m. TO <input type="checkbox"/> First Aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Or: (please check one)			
3. (please check one) <input type="checkbox"/> I received first aid <input type="checkbox"/> I did not receive first aid		4. Name of First Aid Attendant	
5. Name and address of attending physician or qualified practitioner (if any)		6. Was protective equipment being used? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		7. Name of witnesses (if any)	
		8. The supervisor in charge at the time of my injury was	
9. The following describes what happened to cause the injury and includes contributing factors: description of any machinery or objects involved, etc.		OR The following (in cases of occupational disease) describes how exposure occurred. Gases, vapours, dusts, chemicals, radiation, noise, source of infection or other causes are mentioned as appropriate. (please use reverse side of report if necessary)	
10. All apparent injuries received at this time are as follows: Specify part(s) of body injured, indicating right or left.			

PLEASE READ CAREFULLY

"I declare all the information I have given on this report is true and correct and I elect to claim compensation for the above mentioned injuries or disease. I authorize the Workers' Compensation Board (the "Board") and Review Board to obtain or view, from any source whatsoever, including records of physicians, qualified practitioners, medical insurers or hospitals, a copy of records pertaining to examination, treatment, history and employment of the undersigned. Further, I acknowledge that the Board may disclose information from my claim to my employer for purposes of appeal, or may disclose such information to others in accordance with the law, including the *Freedom of Information and Protection of Privacy Act*. I authorize the Board to disclose information from my claim to the designated advocate of my union or similar association. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation without advising the Board."

Worker's signature	Date Month Day Year	Personal health number from your BC CareCard
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ADDITIONAL INFORMATION CAN BE RECORDED ON THE REVERSE SIDE OF THIS REPORT.

Please see the reverse side of this report for telephone and fax numbers.



6A