UBC Faculty & Staff Incident / Accident Report

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

1) **Fax page 1 including the Worker's Report of Injury to Employer (WorkSafeBC Form 6A) and WorksafeBC First Aid Report (Form 55B23) to Health Promotion Programs at 604-822-0572 within 24 hours of injury.**

2) **Complete page 2 within 3 working days after the incident has been reported.**

Do NOT distribute page 1 as it contains confidential information that must be collected to initiate a WorkSafeBC claim.

For more information contact the HPP Claims Assistant 604-822-8759.

1

Was the Accident:

☐ **No medical treatment, no time loss – complete only sections 1, 2 (employee's name, union and crew number only) and 4.**

☐ **Medical treatment (visit doctor, no days off work) – complete sections 1, 2 and 4. (Include Employee's Report Form 6A.)**

☐ **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	**OR**	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: Phone # Email:	Date and Time Reported: (y/m/d) AM/PM
Worker's Department	Worker's Job Title	Was First Aid Given? ☐ Yes ☐ No If **YES** - is First Aid Report included: ☐ Yes ☐ 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.

Body Part Injured: ☐ Left ☐ Right

2

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ 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: ☐ Full time, on-going ☐ Temporary ☐ Part time ☐ Seasonal ☐ Casual ☐ Other_____	Weight: ☐ lbs ☐ kg	Height: ☐ in ☐ cm

Name of Doctor or Hospital Visited	Doctor or Hospital Address:

Name of Witness(es) 1.	Address / Phone #	Do witnesses confirm worker's statement? ☐ Yes ☐ No
2.		

Were the worker's actions at the time of injury for the purpose of the University's business?
☐ Yes ☐ No, If no, explain

Were the activities part of the worker's regular work?
☐ Yes ☐ No, If no, explain

Is there any reason to feel that the injury did not occur as stated?
☐ No ☐ Yes, If yes, explain

Are you aware of any previous pain or disability in the area of the present injury?
☐ No ☐ Yes, If yes, explain

Was any person not employed by UBC responsible for the injury?
☐ No ☐ Yes, Give details, name & address of person.

3

Wage information of injured worker
(If NO time loss, skip this section and go to Sec. 4)

Show normal work week by entering hours worked per day.

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

Worker's Exact Gross Wage (provide one only)
Hourly Employee: $_____/ hour
Monthly Employee: $_____/month

Additions to wages (provide details)
(ie shift premiums, holiday pay, meals . . .)

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? ☐ Yes ☐ No If Yes, describe:	Shift Start Date: (y/m/d)	Has Employee returned to work? ☐ Yes ☐ No	If employee has returned to work - when? (y/m/d)

THE FIRST PAGE IS CONFIDENTIAL AND IS ONLY COLLECTED BY RMS TO INITIATE A WORKSAFEBC CLAIM AS REQUIRED BY LAW. DO NOT DISTRIBUTE SECTIONS 2 & 3 OTHER THAN TO RISK MANAGEMENT SERVICES.

Date Report Completed (y/m/d)	Supervisor's Signature	Supervisor's Name (Please Print)

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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 Promotion Programs 604-822-0572 **3)Send a copy to the Local Safety Committee;**
2)Send the original to the Department Head **4)Post a copy at the work site.**
5) Fax a copy to RMS Insurance Mgr 604 822 6650

1 **Was the Accident:**
☐ **No medical treatment, no time loss – complete only sections 1, 2 (employee's name only) and 4.**
☐ **Medical treatment (visit doctor, no days off work) – complete sections 1, 2 and 4. (Include Employee's Report Form 6A.)**
☐ **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	**OR**	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? ☐ Yes ☐ No If **YES -** is First Aid Report included: ☐ Yes ☐ 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.

Body Part Injured:
☐ Left ☐ Right

4 **Accident Investigation**
(use reverse of page if more space is required)

Was the accident site visited? Yes No

Select one or more causes from each category

Task
- ❑ Lifting
- ❑ Twisting the trunk
- ❑ Lifting overhead
- ❑ Heavy load - Lift
- ❑ Heavy load - Push
- ❑ Heavy load - Pull
- ❑ Awkward load to handle
- ❑ Hot load
- ❑ Sharp edges on load
- ❑ Repetitive motion
- ❑ Stooping
- ❑ Extended reach
- ❑ Incorrect tool
- ❑ Rushing
- ❑ Procedures not followed
- ❑ No "Task" factors
- ❑ Other (Specify)_____

Environment
- ❑ Limited space / constrained posture
- ❑ Housekeeping
- ❑ Variations in floor surface
- ❑ Cold / Hot
- ❑ Wet / slippery
- ❑ Vision obstructed
- ❑ Personal Protective Equipment restrictions
- ❑ No "Environment" factors
- ❑ Other (Specify)_____

Organizational
- ❑ Poor Communication
- ❑ Excessive workload
- ❑ Job / skill training inadequate
- ❑ Planning inadequate
- ❑ Staffing inadequate
- ❑ Poor job design
- ❑ No Standard Operating Procedure available
- ❑ No "Organizational" factors
- ❑ Other (Specify)_____

Equipment
- ❑ Incorrect equipment
- ❑ Defective equipment
- ❑ High force requirement
- ❑ Preventative maintenance inadequate
- ❑ Signage / labeling inadequate
- ❑ Material / equipment failure
- ❑ Equipment vibration
- ❑ No "Equipment" factors
- ❑ Other (Specify)_____

Human
- ❑ Fatigue
- ❑ Illness
- ❑ Knowledge / skill / experience lacking
- ❑ Language difficulties
- ❑ Personal distraction
- ❑ Physical limitations
- ❑ Pre-existing condition
- ❑ No "Human" factors
- ❑ 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)

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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 RMS 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 WORKSAFEBC.

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 WORKSAFEBC. 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 WORKSAFEBC 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 WORKSAFEBC claims assistant after the initial report has been submitted. Please fax an amended form with the appropriate time loss information to RMS 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.

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Section 4- Accident Investigation

Objective: To determine the cause of an accident and to prevent future occurrence

To be conducted by:
- Direct supervisor of the employee.
- Worker safety representative from the Health and Safety Committee.
- May need additional people if specific information is required about specialized types of work or hazards.

To be performed:
- At the actual incident site/location.
- As soon as possible after the incident.
- As accurately as possible; include weights, heights, distances of objects (include pictures if applicable).

Steps:
- Secure the scene.
- Care for the injured.
- Gather and record data.
- Interview all persons involved (witnesses, co-workers, supervisors)
- Check training records, safety analyses, risk assessments previous done for the site.
- Review history- check if there are similar incident at the site or involving employee.

INSTRUCTIONS

Complete Section 4 (Page 2):

Select all applicable factors for each of the five categories listed. There should be a minimum of five boxes checked.

Using the factors identified, determine the basic causes of the incident.

Develop recommendations for each identified cause and assign a completion date.

Attach additional pages if required.

The individual department is responsible for completion and follow-up of recommendations.

Additional Help?
Contact RMS office 604-822-2029 to arrange for assistance from an RMS officer.