



**NATURE OF INCIDENT**

<input type="checkbox"/> Injury	<input type="checkbox"/> Damage	<input type="checkbox"/> Spill	<input type="checkbox"/> Close call
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If the incident was, or may have been the direct result of worker judgment, then post incident drug and alcohol testing may be required.

**A Drug and Alcohol Test Has Been Scheduled**  Yes  No **Date:** \_\_\_\_\_

*The supervisor of the area where the event occurred must complete this form and submit it as soon as reasonably possible. Be as specific as possible and include drawings, photos, additional narrative, as needed.*

**Medical Aid incidents:** Ensure that WCB Reports of Injury or Occupational Illness C060 (workers) & C040 (employers) are completed. **Vehicular incidents:** Ensure the employee has filled out a police report.

**SUPERVISOR CONTACT INFORMATION**

Supervisor name:	Title:	Location of Incident:
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Date of incident: (mo/day/yr)	Time of incident: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date/Time of first knowledge of incident: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date of report:
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Subcontractor involved? If yes, name and contact information:

**INJURED PARTY**

<input type="checkbox"/> No injury	Injured party's name:	Injured party's contact information:
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Injury description:

**WITNESSES AND/OR WITNESS STATEMENT**

Witnesses (name and contact information)	Witness statement attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**PROPERTY DAMAGE**

List property / material damaged:	Nature of damage:
Object / substance inflicting damage:	Approximate cost:

**THE INCIDENT**

**Describe what happened.**

Investigate scene of incident or conditions. Describe who was involved, when and where the incident happened, what happened, and how.

**Why did it happen?**

What actually caused the illness, injury, or incident?

**List immediate actions taken and results.**

**What should be done to prevent a recurrence?**

Use descriptive constructive statements (such as: worker requires additional hazard awareness training; worker needs training in lifting techniques, etc)



POTENTIAL SEVERITY			
<input type="checkbox"/> No Injury Potential	<input type="checkbox"/> No Potential Financial/Environmental Impact		
<input type="checkbox"/> Minor (First Aid)	<input type="checkbox"/> < \$1,000.00 Loss/Damages/Clean Up		
<input type="checkbox"/> Serious (Medical Aid)	<input type="checkbox"/> \$1,000.00 - \$10,000.00 Loss/Damages/Clean Up		
<input type="checkbox"/> Major (Lost Time/Emergency)	<input type="checkbox"/> > \$10,000.00 Loss/Damages/Clean Up		
ACTUAL SEVERITY			
<input type="checkbox"/> No Injury	<input type="checkbox"/> No Financial Loss/Clean Up		
<input type="checkbox"/> Minor (First Aid)	<input type="checkbox"/> < \$1,000.00 Loss/Damages/Clean Up		
<input type="checkbox"/> Serious (Medical Aid)	<input type="checkbox"/> \$1,000.00 - \$10,000.00 Loss/Damages/Clean Up		
<input type="checkbox"/> Major (Lost Time/Emergency)	<input type="checkbox"/> > \$10,000.00 Loss/Damages/Clean Up		
HAZARD ASSESSMENT REVIEW			
Is there a hazard assessment or safe operating procedure that applies to the task and environment when the incident occurred? <i>If yes, review the hazard assessment, answer the following questions, and attach a copy of hazard assessment to this report. If no, please explain why the hazard assessment did not include the task.</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No
Were hazards sufficiently identified? If not, please explain.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Were identified controls adequate and implemented? If not, please explain.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the hazard assessment available and reviewed by the involved worker(s)?			<input type="checkbox"/> Yes <input type="checkbox"/> No
ROOT CAUSE IDENTIFICATION			
<input type="checkbox"/> Skill Deficiency	<input type="checkbox"/> Knowledge Deficiency		
<input type="checkbox"/> Desire Deficiency	<input type="checkbox"/> Judgment Deficiency (Fatigue, D&A, Emotions)		
<input type="checkbox"/> Mechanical Failure	<input type="checkbox"/> Other:		
Explanation of root cause identification:			
CORRECTIVE ACTIONS TRACKING SYSTEM ITEMS			
List action(s) that have or will be taken to prevent a recurrence.	By whom	Scheduled date	Date Completed
AGENCY REPORTING			
INCIDENT REQUIRES REPORTING TO:			
<input type="checkbox"/> WCB	<input type="checkbox"/> AB Environment		
<input type="checkbox"/> WHS	<input type="checkbox"/> Local Authorities		
<input type="checkbox"/> Other:			
AUTHORIZING SIGNATURES			
COMPLETED BY HSE REPRESENTATIVE (PRINT NAME)	SIGNATURE	DATE	
COMPLETED BY WORKER REPRESENTATIVE (PRINT NAME)	SIGNATURE	DATE	
COMPLETED BY SUPERVISOR (PRINT NAME)	SIGNATURE	DATE	
REVIEWED BY MANAGEMENT (PRINT NAME)	SIGNATURE	DATE	