Public Services Health & Safety Association™

Employee Incident Report

RTW-00

Employee Information

Last Name
First Name
Date of Birth (DD/MM/YY)
Home Telephone No.
Work Telephone No.
Employee ID# / SIN
Address
City/Town Province Postal Code
Division/Dept./Unit
Occupation at time of Injury
Check: ☐Full-time ☐Casual ☐Part-time ☐Student
Years of Experience
Was the employee on the job when the injury occurred? (check) ☐YES ☐NO

Description of Incident

Date of Incident (DD/MM/YY)
Time of day AM/PM
Date Reported (DD/MM/YY)
Time of day AM/PM
To whom was the incident reported?
If report is delayed, please explain why.

State the exact sequence of events leading up to the incident. Include an explanation of what the employee was doing.

Did the accident happen on the employer's premises?

What caused the injury/ illness?

Identify the sizes, weights & types of equipment involved.

Type of Incident (check one—definitions on reverse):

1 ☐ Struck/Caught
2 ☐ Overexertion
3 ☐ Repetition
4 ☐ Fire/Explosion
5 ☐ Fall
6 ☐ Harmful Substances/Environmental
7 ☐ Assault
8 ☐ Slip/Trip
9 ☐ Motor Vehicle Incident

Witnesses

Names, positions, & phone numbers of witnesses or persons having knowledge of the incident.

Cause

Was the accident/illness:
1☐A Sudden, Specific Event/Occurrence? 2☐Gradually Occurring Over Time? 3☐An Occupational Disease? 4☐A Fatality?

Direct causes (check one – see reverse): 1☐Physical/Environmental 2☐Personal
Basic causes (check one – see reverse): 1☐Job factors 2☐Personal factors

Correction

Action(s) Taken	CORRECTED (check box)	PLANNED (check box)	Date (DD/MM/YY)
1	☐	☐	
2	☐	☐	
3	☐	☐	
4	☐	☐	
5	☐	☐	
6	☐	☐	
7	☐	☐	

Examples of Actions:
1. Reinstruction of person involved
2. Reassignment of person
3. Order job safety analysis done
4. Improve personal protective equipment
5. Action to improve inspection
6. Equipment repair or replacement
7. Correction of congested area
8. Installation of guard or safety device
9. Actions to improve design/procedure
10. Check with manufacturer
11. Inform all department supervisors
12. Discipline of persons involved
13. Other:

Injury

Describe the illness or injury, part of body involved and specify left or right side.

Are you aware of any prior similar or related problem, injury, or condition? If yes, please explain:

No injury (check one)
1☐Hazardous situation

Injury – No WSIB Claim (check one)
1☐First aid
2☐No aid

WSIB Claim Treatment Memorandum (check one)
1☐Health care (medical aid)
2☐Lost time

Occupational Health

Did employee seek medical attention? (check one) 1☐No 2☐Yes
Did employee visit health service? (check one) 1☐No 2☐Yes
Did employee visit emergency? (check one) 1☐No 2☐Yes
If Yes, ER Physician's Name
Tel.No.

Did employee visit family physician? (check one) 1☐No 2☐Yes
If Yes, Physician's Name
Tel.No.
Physician's Address

Will the employee undertake: (check one)
1☐Regular duties
2☐Modified duties
3☐Remain off work

Has the employee had a similar disability? (check one)
1☐Yes
2☐No
3☐Unknown

Check attachments to this report.
1☐Statements
2☐Photographs
3☐Treatment memo
4☐Other – specify:

EMPLOYEE SIGNATURE Date

MANAGER SIGNATURE Date

OCC. HEALTH DEPT. SIGNATURE Date

This Information is to be used for completion of WSIB Claim Form 7

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