

UBC OKANAGAN FACULTY & STAFF ACCIDENT/INCIDENT REPORT

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

- 1) Fax page 1 including the *Worker's Report of Injury/Incident to Employer* (WCB Form 6A) to the Health Safety & Environment Manager at 807-9591 within 24 hours of injury.
 - 2) Complete page 2 within 3 working days after the incident has been reported and fax to the Health Safety & Environment Office at 807-9591.
- For more information contact the Health Safety and Environment Office at 807-8621.

1	Check one box only: <input type="checkbox"/> Incident did not result in injury or injury with no medical aid and no time loss – complete only shaded section on this page and all of section 4 on reverse page <input type="checkbox"/> Incident resulted in medical treatment (doctor/hospital visit) but no time loss – complete sections 1, 2 & 4. (Include Employee's Report Form 6A) <input type="checkbox"/> Incident resulted in 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) <div style="text-align: right;">AM/PM</div>			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) <div style="text-align: right;">AM/PM</div>		Supervisor of worker involved: Phone # Email:			Date and Time Reported: (y/m/d) <div style="text-align: right;">AM/PM</div>			
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			
2	<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 (Include Area Code)			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) 1.		Address / Phone #					Do witnesses confirm worker's statement? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2.										
Were the worker's actions at the time of injury/incident 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/incident 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 injured area? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, explain										
Was any person not employed by UBC responsible for the injury/incident? <input type="checkbox"/> No <input type="checkbox"/> Yes, Give details, name & address of person.										
3	Wage information of injured worker If NO time loss, skip this section and go to Section 4.					Worker's Exact Gross Wage (provide one only)		Additions to wages (provide details) (ie shift premiums, holiday pay, meals . . .)		
	Show normal work week by entering hours worked per day.					Hourly Employee: \$ _____ / hour				
					Monthly Employee: \$ _____ /month					
	S	M	T	W	T	F	S			
Wk #1								Date and time last worked after injury: (y/m/d) <div style="text-align: right;">AM/PM</div>		
Wk #2								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, please state when: (y/m/d)				
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 & 3 OTHER THAN TO THE UBCO HEALTH SAFETY & ENVIRONMENT OFFICE, AND HSE VANCOUVER.										
Date Report Completed (y/m/d)			Supervisor's Signature				Supervisor's Name (Please Print)			

