Type of incident:

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| --- | --- | --- |
| **О** serious injury | **О** serious incident | **О** first aid **О** medical aid |
| **О** potentially serious incident | **О** property damage | **О** work refusal **О** violence |
| **О** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Required immediate reporting to Government of Alberta, Occupational Health and Safety **1-866-415-8690 О** YES **О** NO | | Date and time reported:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Worker name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Worker job title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Date of incident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Time:\_\_\_\_\_\_\_ **О** AM **О** PM |
| Incident reported to: **О** first aider **О** supervisor **О** another worker  **О** health & safety committee member **О** health & safety representative  **О** other (job title) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Location of incident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| Witness Name: | Were statements taken: |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **О** YES (attached) **О** NO |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **О** YES (attached) **О** NO |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **О** YES (attached) **О** NO |

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| --- | --- |
| Report reviewed by: |  |
| **О** supervisor **О** health & safety committee member **О** health & safety representative  **О** employer **О** prime contractor **О** other (job title) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ | |

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| Description of incident:  Ensure the investigation describes:   1. what was seen or heard **immediately before** the incident. 2. what was seen or heard **during** the incident. 3. what was seen or heard **immediately after** the incident | Sketch/diagram/photos attached **О** YES **О** NO |
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| **Direct Cause**  **Identity what hazard/s existed immediately before the incident occurred:**  Describe the action, event or force that is the immediate or primary agent which led to the incident: |
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| **Indirect cause**  **Identify what environmental or personal (job) factors allowed the direct cause to develop**  Describe what did not directly cause the incident but contributed to the outcome: |
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| **Root Cause**  **Identify which Safety Program component/element allowed the direct and indirect causes to develop**   |  | | --- | | ❒ Inadequate program  ❒ Inadequate program standards  ❒ Inadequate compliance with program standards |   Describe the basic conditions that allowed each of the direct/indirect causes to occur: |
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| **CORRECTIVE ACTION PLAN** | | | |
| **Details** | **By Whom** | **Target Date** | **Action Complete** |
|  |  |  | ❒ |
|  |  |  | ❒ |
|  |  |  | ❒ |
|  |  |  | ❒ |
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**DEPARTMENT MANAGER/SUPERVISOR:**

❒Communicate outcome and action plan with employee

Employee Signature**:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Department Manager/Supervisor Signature*:* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: \_\_\_\_\_\_\_\_\_\_

**HSC:**

❒ Incident Reviewed at Site OH&S Committee

Co-chair Signature**:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Co-chair Signature**:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_