WORKPLACE INCIDENT REPORT FORM

Company Name:

Date of Report:

Report Type: ☐ Incident ☐ Injury ☐ Near Miss

Full Name of Person Reporting	Role	Supervisor	
			☐ Witness ☐ Impacted
Additional Involved Person(s)	**Role**	**Supervisor**	
			☐ Witness ☐ Impacted
			☐ Witness ☐ Impacted
			☐ Witness ☐ Impacted
			☐ Witness ☐ Impacted

Date of Incident/Injury/Near Miss:

Date Reported to First Aid:

Date Reported to Supervisor:

☐ Any immedate hazard has been controlled

Location of Incident:

Incident Result

- ☐ Unwitnessed Incident - No employees present
- ☐ Near Miss Incident - Dangerous incident with no illness/injury
- ☐ Minor Injury - Returned to regular duties
- ☐ Moderate Injury - Returned to alternate duties
- ☐ Major Injury - Healthcare provider needed with no time off
- ☐ Severe Injury - Healthcare provider needed and time off required

First Aid Attendant:

_____

What Happened?

Signature of Person Reporting

_____

Signature of Supervisor Receiving Report

_____

This form is not to be used in lieu of any required incident/injury reporting forms. Please ensure all required forms are completed and submitted per WorkSafeBC requirements.

Forms Required (Office Use Only)

- ☐ Employee Injured - Form 6 - Employee Report of Incident/Occupational Disease
- ☐ Employee Injured - Form 7 - Employer Report of Injury/Occupational Disease
- ☐ Severe injury/illness or could have caused severe injury/illness – Employer Incident Investigation Report
- ☐ Other: _____