

Accident Investigation Report

Use this report to record the results of your accident investigation.

WCB EMPLOYER # _____	WORKER'S LAST NAME _____
OPERATING LOCATION # _____	FIRST NAME _____
EMPLOYER'S NAME (as registered with the WCB) _____	MIDDLE NAME _____
MAILING ADDRESS _____	MAILING ADDRESS _____
_____	CITY _____ POSTAL CODE _____
CITY _____ POSTAL CODE _____	PHONE # _____
ACCIDENT/INJURY SITE ADDRESS _____	SOCIAL INSURANCE # _____
_____	DATE OF BIRTH _____
CITY _____	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
TYPE OF BUSINESS _____	WEIGHT _____
EMPLOYER'S PHONE NUMBER _____	HEIGHT _____
WORKER'S OCCUPATION _____	

DATE AND TIME OF ACCIDENT/INJURY M____D____Y____ AT _____HR____MIN. am pm
NATURE OF REPORTABLE EVENT Dangerous Occurrence (no injury) First Aid Medical Treatment Only (no time loss)
 Worker Injury (with time loss) Fatal (date of death) M____D____Y____

DESCRIPTION OF THE INCIDENT (Where applicable, please give detailed description of structures, and makes, models, and serial numbers of equipment and tools involved in this accident. Include names of witnesses. Use a separate sheet if necessary.)

ACCIDENT CAUSE(S) (e.g., methods, equipment, materials, and people)

CONTRIBUTING FACTOR(S)

CORRECTIVE ACTION(S) TO AVOID RECURRENCE

HEALTH AND SAFETY CONTACT _____

PHONE # _____

INVESTIGATOR NAME(S) _____

PHONE #(S) _____

EVENT WITNESS NAME(S) _____

PHONE #(S) _____

FOLLOW-UP ACTION(S) (include person responsible and date for completion)

SIGNATURE OF INVESTIGATOR(S) _____ DATE _____