



**INJURED PARTY/COMPLAINANT TO COMPLETE** Sections A & B, **SIGN, DATE & SUBMIT** to your immediate supervisor/department within 24 HOURS of the event.

Section A: General Information (Injured Party/Complainant)	
Last Name	First Name
Faculty/Staff <input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/>	McGill ID Number
Department	Position
Daytime Phone Number	Evening Phone Number

Section B: Description of the Event	
<b>When</b>	Date of Event (MM/DD/YYYY) Time of Event
	Date Reported Time Reported
<b>Where</b>	Location of Event (Laboratory, office, stairs, etc.) Building
	Floor & Room
<b>What</b> happened? (Description of the event and how it occurred)	
Were you injured? (Description of injury, including parts of the body)	
What factors contributed to the event?	
How could the event have been avoided?	
Was First aid administered? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, by whom?	
Signature of Injured Party/Complainant	Date

*If form completed by someone other than the injured party, please fill out the following lines:*

Form Completed by:	Telephone Number
Signature	Date



# McGill ACCIDENT, INCIDENT & OCCUPATIONAL DISEASE REPORT FORM

**IMMEDIATE SUPERVISOR TO COMPLETE** Sections C & D, **SIGN, DATE & SEND** to Environmental Health & Safety within 24 HOURS. **IF injury occurred, SEND** copy to Benefits Office (688 Sherbrooke Street West, 14<sup>th</sup> Floor - Fax 514.398.6889).

Section C: General Information	
Supervisor's Last Name	Supervisor's First Name
Department	Position
Phone Number	Email
If there was a delay in reporting this event, list reason(s):	
Material Damage      YES <input type="checkbox"/> NO <input type="checkbox"/> Approximate Value:	
Section D: Preventative Measures	
Cause of event – Root Causes (e.g., unsafe equipment, lack of training, etc.)	
What corrective actions are being taken to prevent recurrence?	
Have person(s) involved received training or instruction in the work or activity being carried out?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Was there any supervision of the work or activity being carried out?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Supervisor's Comments (Additional information on event)	
If injury occurred, please check one:	
<input type="checkbox"/> No First-Aid administered, returned to work	<input type="checkbox"/> Saw a physician, returned to light duty
<input type="checkbox"/> First-Aid administered, returned to work	<input type="checkbox"/> Saw a physician, time loss
<input type="checkbox"/> Saw a physician, returned to work	<input type="checkbox"/> Refused medical treatment
Supervisor's Signature	Date

### EH&S Office Use Only

Reviewed by	Date
Distribution: <input type="checkbox"/> Risk Management <input type="checkbox"/> Benefits Office, HR <input type="checkbox"/> Dept. Chair/Head <input type="checkbox"/> Dean of Students	
Follow-Up: <input type="checkbox"/> Supervisor <input type="checkbox"/> Building Director <input type="checkbox"/> Facilities Management <input type="checkbox"/> Waste Management <input type="checkbox"/> Dept. Chair/Head <input type="checkbox"/> Dept. Safety Com. <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	