UNIVERSITY INJURY/NEAR-MISS REPORT

Université Concordia University — ENVIRONMENTAL HEALTH AND SAFETY

Injured party/informant to complete sections A & B, sign, date and submit to your immediate supervisor/instructor within 24 hours of the injury. By submitting this form, the injured party/informant consents and authorizes Environmental Health and Safety to distribute the information in this form to the appropriate parties, which could include the CNESST. Refer to Policy on injury reporting and investigation (VPS-42) for further information.

Section A: Injured Party/Informant Details	
Surname:	First name:
Home phone #:	Office or cell phone #:
Email address:	Concordia ID #:
Department:	Union or Association:
Status: ☐ Faculty/Staff ☐ PhD/Postdoc. ☐ Graduate Student ☐ Undergraduate Student ☐ External Contractor ☐ Visitor	

Section B: Description of injury/near-miss	
☐ Injury ☐ Occupational disease ☐ Near-miss (no injury) ☐ Other: _____ If Injury or Occupational Disease selected, have immediate supervisor complete sections C&D.	
Date of event (YYYYMMDD):	Time: ☐ a.m. ☐ p.m.
Location of incident Campus: Bldg.: Floor/Room #:	
Description of situation and how it occurred:	
Were you injured? (If yes, describe injury including body parts injured):	
How could the injury/near-miss have been avoided? Corrective measures to prevent reoccurence.	
Was first aid administered? ☐ Yes ☐ No If yes, by whom? ☐ Security ☐ CERT ☐ Self ☐ Health Services ☐ Other_____	
Witness name: _____ Phone#: _____	
Injured Party/Informant Signature: Date:	

This side to be completed by injured party / informant

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

Form completed by:	Phone #:
Signature:	Date:

Supervisor/instructor to complete sections C & D on page 2 (reverse)

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Immediate supervisor/instructor to complete Sections C & D, sign, date & send to Environmental Health & Safety within 24 hours of the injury.

Section C: Supervisor's/Instructor's Details

Surname:	First name:
Department:	
Phone #:	Email:
If injury was reported more than 24 hours after the injury, list reason(s):	
Material Damage: ☐ Yes ☐ No Describe material damage: Approximate value:	

Section D: Preliminary Investigation

Did you immediately visit the location of the injury? ☐ Yes ☐ No

What are the causal factors of the injury (ex. unsafe equipment, lack of training, etc.)?

What corrective measures are being taken to prevent reoccurrence?

Has the person(s) involved received training or instruction in the work or activity being carried out? ☐ Yes ☐ No

Comments (Additional information on injury).

If injury occurred, please check one: ☐ No First-Aid administered, returned to work/academic activities ☐ First-Aid administered, returned to work/academic activities ☐ Saw a physician, returned to work/academic activities	☐ Saw a physician, returned to work on light duty until further notice ☐ Saw a physician, lost time from work ☐ Refused medical treatment
Supervisor's/Instructor's Signature:	Date:

This side to be completed by supervisor/instructor

EHS Office Use Only

Reference #: Reviewed by: Date:

☐ Benefits ☐ Risk Management ☐ H&S Committee_____ Union Representative_____

Supervisor_____ EHS_____ Security Report #_____