

# Employer Incident Investigation Report



Please refer to the companion [GUIDANCE DOCUMENT](#) for assistance completing the investigation and this form.

## 1. Employer's Information

<b>Employer's Name</b> Chilliwack School District No. 33		<b>WorkSafeBC Account #</b> 035838
<b>Employer's Head Office Address</b> 8430 Cessna Drive		
<b>City</b> Chilliwack	<b>Province</b> BC	<b>Postal Code</b> V2P 7K4
<b>Supervisor's Name</b>		
<b>Supervisor's Email Address</b>		<b>Supervisor's Phone Number (Include Area Code)</b>

## 2. Injured Persons

Last Name	First Name	Job Title

## 3. Place, Date, & Time of Incident

<b>Location Where Incident Occurred (Street Address)</b>		
<b>City</b> Chilliwack	<b>Province</b> BC	<b>Postal Code</b>
<b>Date of Incident (YYYY-MM-DD)</b>		<b>Time of Incident</b> <input type="checkbox"/> AM <input type="checkbox"/> PM

## 4. Type of Occurrence (Select All That Apply)

<input type="checkbox"/> Serious injury to a worker	<input type="checkbox"/> Incident of fire or explosion with potential for serious injury
<input type="checkbox"/> Major structural failure or collapse	<input type="checkbox"/> Minor injury or no injury but had potential for causing serious injury
<input type="checkbox"/> Major release of hazardous substance	<input type="checkbox"/> Injury requiring medical treatment beyond first aid

**This employer incident investigation report is NOT required if none of the above applies or if this incident is a vehicle accident occurring on a public street or highway.**

## 5. Report Type (Select All That Apply) If this is a revised version of a previous report, check here

<input type="checkbox"/> <b>Preliminary Investigation Report</b>  Provide a copy to <a href="mailto:healthandsafety@sd33.bc.ca">healthandsafety@sd33.bc.ca</a> within 48 hours	<input type="checkbox"/> <b>Interim Corrective Active Report</b>	<input type="checkbox"/> <b>Full Investigation Report</b>  Must be provided to <a href="mailto:healthandsafety@sd33.bc.ca">healthandsafety@sd33.bc.ca</a> within 30 days	<input type="checkbox"/> <b>Full Corrective Action Report</b>
<b>Report Date</b> (yyyy-mm-dd)	<b>Report Date</b> (yyyy-mm-dd)	<b>Report Date</b> (yyyy-mm-dd)	<b>Report Date</b> (yyyy-mm-dd)
<b>Date Sent</b> (yyyy-mm-dd)		<b>Date Sent</b> (yyyy-mm-dd)	

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**6. Witnesses**

Last Name	First Name	Job Title

**7. Other Persons Whose Presence Might Be Necessary for Proper Investigation**

Last Name	First Name	Job Title

**8. Sequence of Events that Preceded the Incident**

Describe events earlier that day or even in previous days/weeks that led up to the incident. Examples may include events such as training or changes in equipment, procedures, supervisors, or task locations.

**9. Unsafe Conditions, Acts, or Procedures that Significantly Contributed to the Incident**

Describe anything, or the absence of anything, that contributed to the hazard such as poor housekeeping or poor visibility, using equipment without guards, or the lack of safe work procedures or instruction.

**10. (OPTIONAL SECTION – Complete Only If There Has Been a Serious Injury) Nature of Serious Injury**

- |   |  |
|---|--|
| <input type="checkbox"/> Life threatening or resulting in loss of consciousness   | <input type="checkbox"/> Punctured lung or other serious respiratory condition |
| <input type="checkbox"/> Major broken bones in head, spine, pelvis, arms, or legs | <input type="checkbox"/> Injury requiring CPR or other critical intervention   |
| <input type="checkbox"/> Major crush injuries or cuts with severe bleeding        | <input type="checkbox"/> Serious chemical or heat/cold stress exposure         |
| <input type="checkbox"/> Severe (third-degree) burns                              | <input type="checkbox"/> Other (specify)                                       |



### 11. Brief Description of the Incident

In ONE or TWO sentences, briefly summarize the event or events that caused the injury.

### 12. Corrective Actions Identified and Taken to Prevent Recurrence of Similar Incidents

	Action (Required in Preliminary Report and Interim Corrective Action Report. Update in Full Report, if Necessary)	Action Assigned To (Name and job title)	Expected Completion Date (yyyy-mm-dd)	Completed Date (yyyy-mm-dd)
a)				
b)				
c)				

### 13. OPTIONAL – Explanation of Blank Areas on This Preliminary Report

If there are blank areas explain this lack of information.

### 14. Persons Who Carried Out or Participated in the Preliminary Investigation

Representative	Name	Job Title	Signature (optional)	Date Signed (yyyy-mm-dd)
Employer Representative				
Worker Representative*				
Injured Worker				

\*the worker representative is not required at this stage, but is encouraged if practical.

### END OF PRELIMINARY INVESTIGATION REPORT

Completing sections 1-14 satisfies the requirements for a Preliminary Investigation Report and an Interim Corrective Action Report.

**Note:** If this was a simple investigation and **all needed corrective actions have been completed within 48 hours**, the Preliminary and Full Investigation portions of the report can be completed at the same time. If so, you can check both the Preliminary Investigation Report and the Full Investigation Report boxes in section 5 on page 1.

Copies of **all** reports must also be provided to the joint occupational health and safety committee.



**15. Brief Description of the Incident**

Analyze the facts and circumstances to identify underlying factors that led to the incident. Underlying factors include those that made the unsafe conditions, acts, or procedures in the Preliminary Report possible. Update items from sections 8 and 9 only if an update is needed.

**16. Full Description of the Incident**

Use the brief description from the Preliminary Report (section 11) and update it only if necessary. If not needed copy and paste section 11 here.

**17. Additional Corrective Actions Necessary to Prevent Recurrence of Similar Incidents**

	<b>Additional Corrective Action</b> (Required in Full Report and Full Corrective Action Report)	<b>Action Assigned To</b> (Name and Job Title)	<b>Expected Completion Date</b> (yyyy-mm-dd)	<b>Completed Date</b> (yyyy-mm-dd)
a)				
b)				
c)				

# Employer Incident Investigation Report



**18. Persons Who Carried Out or Participated in the Full Investigation**

Representative	Name	Job Title	Signature (optional)	Date Signed (yyyy-mm-dd)
Employer Representative				
Worker Representative				
Injured Worker				

**\*at least one worker representative must be involved during the full investigation of the incident.**

**19. Other Relevant Workplace Parties**

Company Name	Contact Person	Contact Number or Email Address

**END OF FULL INVESTIGATION REPORT**

Completing sections 15-19 satisfies the requirements for a Full Investigation Report and a Full Corrective Action Report.

Employers are required to submit **full** investigation reports to WorkSafeBC **within 30 days\* of the incident**. Use the submit button to forward this report to health and safety. The Occupational Health & Safety Manager will submit the report to WorkSafe on your behalf.

Copies of **all** reports must also be provided to the joint occupational health and safety committee.