



Critical Injury Incident Investigation Report Form

CRITICAL INJURY INVESTIGATION REPORT FORM

SECTION 1: NOTIFICATION INFORMATION

How did you become aware of the incident?

By Phone Email Verbally Other

Date:

Name of person who notified you:

Their phone #:

Their Location:

Date of Notification:

Time of Notification:

Incident Location:

SECTION 2: NOTIFICATION REQUIREMENTS

Identify individuals notified, phone numbers and time notified.

*Note: Contacts marked by * are mandatory per Sec. 51.(1), OHSA.*

	Individual	Phone #	Date	Time
* MOL Inspector:				
* H&S Rep./Members JHSC:				
* Union rep:				
Emergency Medical Services:				
Manager/Supervisor/Principal:				
Health and Safety Specialist:				
Employee Wellness:				
Others (Explain)				



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SECTION 3: INJURED PARTY INFORMATION

Worker

Non-Worker

Injured Party Name:

Phone:

Work Location Time of Incident:

Injury Details:

Date, Time, Location Transferred to Medical Facility/for Medical Assessment:

SECTION 4: OTHER PERSONS INVOLVED OR WITNESSES

Attach signed witness statements

Name:

Address:

Telephone:



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SECTION 5: HOW DID THE INCIDENT OCCUR?

Record in detail what happened:

Picture/diagram of scene:

Causes (Check all that are applicable):

Conditions		Practices	
<input type="checkbox"/>	Congestion/restricted area	<input type="checkbox"/>	Improper practice
<input type="checkbox"/>	Poor housekeeping	<input type="checkbox"/>	Improper procedure
<input type="checkbox"/>	Slip/trip/fall hazards	<input type="checkbox"/>	Unsafe loading/placement
<input type="checkbox"/>	Lack of appropriate furniture/equipment/tool/material	<input type="checkbox"/>	Use of defective equipment/material
<input type="checkbox"/>	Design/arrangement of furniture/equipment	<input type="checkbox"/>	Altering/modifying equipment
<input type="checkbox"/>	Defective tool/equipment/material	<input type="checkbox"/>	Not using personal protective equipment/improper use
<input type="checkbox"/>	Ventilation	<input type="checkbox"/>	Inappropriate conduct
<input type="checkbox"/>	Inadequate warning system	<input type="checkbox"/>	Other (explain)
<input type="checkbox"/>	Fire and explosion hazards	<input type="checkbox"/>	
<input type="checkbox"/>	Irate client/employee action	<input type="checkbox"/>	
<input type="checkbox"/>	Adverse weather	<input type="checkbox"/>	
<input type="checkbox"/>	Other (explain)	<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	



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What are the reasons for the existence of these practices/conditions?

Prevention/Corrective Action (Check all that apply. Mark with 'P' those actions planned, but not yet carried out):

	Training/instruction of person involved		Recommend development/improvement to training program
	Improved work procedures		Reassess work standards
	Inform staff of safe work procedure		Improve housekeeping
	Perform job safety analysis		Improve inspection procedures
	Inform staff of hazards and protective measures		Tools/equipment/furniture/materials repair or replacement
	Improve engineering/design		Environmental assessment
	Other (explain)		



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SECTION 6: COMMENTS/NOTES

Additional Information:

Investigated By:

Principal's/ Manager's Signature	Name (print)	Date (dd-mm-yy)
JH&SC/ H&S Rep. Signatures	Name (print)	Date (dd-mm-yy)

Distribution List:

- Ministry of Labour
- H&S Rep./JH&SC
- Union
- H&S Specialist
- Other (e.g. HR, employee wellness)



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WITNESS STATEMENT FORM

Instructions: In order to review the facts of this incident and provide recommendations for preventing it from recurring, please answer the following questions.

Date of Injury / Incident:

Name of Witness:

Address of Witness:

Details of interview:

Witness Signature	Name (print)	Date (dd-mm-yy)
Interviewer Signature	Name (print)	Date (dd-mm-yy)



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CORRECTIVE ACTION FORM

Date:

Date of Injury / Incident:

Corrective action taken (as indicated on the Critical Injury Investigation Form)

Recommendation	Date Assigned	Person Responsible	Status (who & when competed/ to be completed)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Reviewed By:

Principal's/ Manager's Signature	Name (print)	Date (dd-mm-yy)