pollard Enterprises Ltd.

Supervisors Accident Investigation Report - Injured Worker

Employer: _____ Employee #: _____ Project #: _____

Address: _____ Name of Injured Worker: _____

Constructor/GC : _____ Address of Injured: _____

Address: _____

Date of Accident: _____ Time of Accident: _____ Accident Location: _____

Birthdate: _____ SIN # of Injured: _____ Phone # of Injured: _____

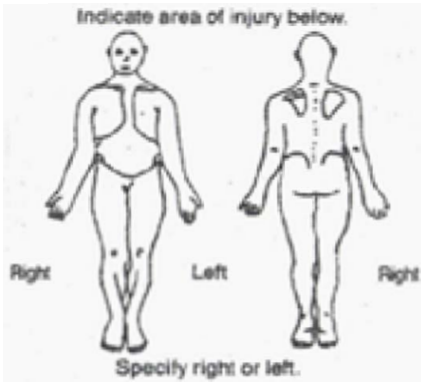
Supervisor on Site: _____ 1st Person Notified of Accident on Site: _____

Date & Time Accident Reported: _____ Office Notified? Yes No Time: _____

Site Conditions: (Weather, Housekeeping, Lighting) _____

_____

Circle Areas Worker Injured Below:



Sketch Workplace Area Below - Mark Location of Accident

Describe the Accident: Detail all equipment, objects, condition of tools, events, and circumstances that led to the accident. Indicate property damage, size and weight of equipment or material involved, person in most control of object, equipment or substance at the time. Indicate position of witnesses. Obtain measurements and measure distances.

_____

_____

_____

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_____

_____

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Nature of the Injury: (Describe injuries - Ex. Cuts, lacerations, bruises, pained areas, blood loss, etc.)

_____

_____

_____

_____

_____

Lost Time Injury Information Only:

How long Will Worker Be Off Work For: _____ Date & Hour Last Worked: _____

Normal Working Hours in Week: (Include OT if regular work includes standard OT Hours) _____

Start & Finish Time of Shift: _____ Was Anyone Else Directly Involved in the Accident (Third Parties) _____

If so, detail actions, give addresses & phone numbers.

Names, Addresses & Phone Numbers of Witnesses or Workers in the area at the time of the Accident:

1.
2.
3.

Was a treatment memorandum issued to the injured worker? _____ Did the worker sign it? Yes No

Name, Address, & Phone Number of attending Physician, Surgeon or Clinic: (Is this the Family Doctor?)

_____

_____

Did you accompany injured worker to Medical Treatment? _____ Name of Escort: _____ Approved to return to work? _____

Any other vital details not listed before: _____

_____

_____

_____

Date & Time Reported to Ministry of Labour (if required): _____ **Name of MOL Rep:** _____

List PPE Used by Worker on Site: _____

What other protective equipment should have been used on site (if any): _____

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What Actions have been taken to ensure that this incident is not repeated in the future?:

_____

_____

_____

_____

_____

_____

_____

_____

Has the employee had a previous similar disability?: _____ **If yes, when?:** _____

Did the employee collect Compensation as a result?: Yes No Name of Employer at the time: _____

Was there any serious or willful misconduct involved? Neglecting to follow Company Safety Rules or report the accident immediately?

_____

_____

Are there any underlying pre-existing health conditions which could have played a part in the accident or aggravate the duration of disability? _____

_____

Do you feel the need to investigate this claim further?: Yes No If so, please explain why: _____

_____

Was this report completed with the injured worker present?: Yes No If not, please explain why: _____

_____

Was the investigation of this claim conducted immediately?: Yes No If not, Date and Time Conducted: _____

Name of Person Who Conducted Investigation: _____ **Name of Foreman:** _____

_____ _____ _____

Superintendent **Foreman** **Date**

_____ _____

Employee **Health & Safety Manager**