Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

WORK RELATED INJURY / NEAR MISS FORM

Both sides of this form are to be completed by the Employee immediately following Injury/Near Miss (including incidents of violence and/or abuse both physical and verbal) ***PLEASE PRINT CLEARLY***

DESCRIPTION:

Incident Date: _______/_______/_______ **Incident Time:** _______ **am/pm**
d m y

Location: I was in/at (please complete all that apply)
☐ Site Interior: Building: ______________________________ i.e. Lodge, Tower
Floor/Wing: ___________ Room/Area: ________________________
☐ Site Exterior: ____ i.e. parking lot
☐ Client's Address ____

Others involved in the incident:
☐ Patient ☐ Other Worker ☐ Family Member ☐ Public
Identifier: (name, HRN, etc.) ____

Activity: What was your task/duty at the time the incident occurred: e.g. walking, carrying, patient transfer? ____

Detailed Description of Incident:

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Witness: ☐no ☐yes Name:

PERSONAL INFORMATION:

First Name: ________________________ **Last Name:** ________________________

Gender: ☐Female ☐Male **Primary Phone Number:** ___________________

Job Title: ________________________ **Department:** ________________________

# of years in this position _______

Job Status: ☐ Full Time ☐Part Time ☐Casual

Do you have another position at this site? ☐no ☐yes

Actions Following Incident: (please check all that apply):
☐Report Only ☐First Aid ☐Lost Time Injury
☐Saw/will see healthcare provider: ____
Name of provider or location

THIS AREA TO BE COMPLETED BY OESH ONLY

OESH File #: ________________________________

Employee #: ____________________ **FTE:** _______

Union: ________________________________

Home Address: ____________________________

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Date of Birth: _______/___________/_________

Incident Category
- ❑ Near Miss – No Injury
- ❑ Injury – Work Related
- ❑ Illness – Work Related
- ❑ Motor Vehicle Incident
- ❑ Property Damage
- ❑ Chemical Spill
- ❑ Infestation
- ❑ Violence/Abuse
- ❑ Other:

Investigation Form
Date Sent: _____/_______/_______ **To:** ____________________________________
d m y *Manager and Buddy Names*

OESH Specialist: ☐ OHN ☐MSIP ☐Safety **Name:** __________________

WCB Claim # *(where applicable)*: ____

PLEASE COMPLETE BOTH PAGES

Employee Name:

PART OF BODY INJURED: (Please check off all that apply)				**No Body Part Injured:** ☐			
Head	☐R ☐L	Neck	☐R ☐L	Shoulder	☐R ☐L	Hip (s)	☐R ☐L
Face	☐R ☐L	Back–Upper	☐R ☐L	Arm – Upper	☐R ☐L	Leg - Upper	☐R ☐L
Eye(s)	☐R ☐L	Back–Lower	☐R ☐L	Arm – Lower	☐R ☐L	Leg - Lower	☐R ☐L
Nose	☐R ☐L	Abdomen	☐R ☐L	Elbow	☐R ☐L	Knee	☐R ☐L
Mouth/Teeth	☐R ☐L	Pelvis	☐R ☐L	Wrist	☐R ☐L	Ankle	☐R ☐L
Ear(s)	☐R ☐L	Chest	☐R ☐L	Hand	☐R ☐L	Foot	☐R ☐L
Hearing	☐R ☐L	Cardio/Respiratory	☐R ☐L	Finger(s)/Nails	☐R ☐L	Toe(s)/Nails	☐R ☐L
☐Other: *please specify*							

NATURE/TYPE OF INJURY: (Please check of all that apply)				**No Injury:** ☐	**Psychological** ☐	Verbal Abuse ☐	
Sprain/Strain	☐	Follow Post Exposure Protocol	☐	Foreign Object	☐	Internal Injury	☐
Bruise/Crush/Abrasion	☐	Needlestick	☐	Chemical Exposure	☐	Concussion	☐
Burn/Scald	☐	Blood/Body Fluid Splash	☐	Dermatitis/Rash	☐	***Loss of Consciousness*** *	☐
Burn – Third Degree *	☐	Bite – Human	☐	Exposure to cold/heat	☐	***Electrical Contact*** *	☐
Cut/Laceration minor	☐	Bite – Animal/Insect	☐	Hearing Loss/Deafness	☐	***Fracture/Dislocation*** *	☐
Cut/Laceration requiring treatment at hospital *	☐	Infection: *specify*	☐	Illness–Work Related : *specify*	☐	***Amputation*** *	☐
☐Other:						* Serious Injury-SEE BELOW	

REPORT IMMEDIATELY TO MANAGER/SUPERVISOR AND **COMPLETE THIS SECTION**

INM Reported to

Full Name: ____________________________ Position: ___________________________ on _____/_______/______ at ________ am/pm

day month year time

END OF EMPLOYEE REPORTING SECTION

On duty Manager/Supervisor must forward both pages immediately to OESH by email to inmintake@wrha.mb.ca *or Fax* 204-944-8417.

DO NOT SEND via INTERDEPARTMENTAL MAIL

An investigation form will be forwarded to the Immediate Manager by email for completion.

Manager/Supervisor to determine if additional reporting is required as follows

Serious Incidents: If the incident checked above is **BLUE** *, this means that it is considered a serious injury under the Workplace Safety and Health Act and must be reported immediately to the Provincial Workplace Safety and Health Division @ 204-945-3446 (regular working hours) or 204-945-0581 (after working hours). ☐yes – Name of Officer Contacted:

Patient Safety Event Reporting: through RL6 is also required if the incident meets the criteria. ☐yes – Incident #

IRIMS: An IRIMS (security) report through RL6 is also required if the incident meets the criteria. ☐yes – Incident #

Critical Incident Stress Management (CISM) must be offered where a traumatic event falls beyond the usual range of human experience. These events can cause unusually strong emotional and stress reactions, which can overwhelm how a person copes. Please consult the Operational Procedure on CISM.