## **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 violent, aggressive or reactive behaviours both physical and verbal).

\*\*\*PLEASE PRINT CLEARLY\*\*\*

First Name:	EMPLOYEE PERSONAL	<b>INFORMATION:</b>										
Email:    Site:	First Name:		Last Name:		Gender:	☐ Female	■ Male					
Site:	Work Phone:		Home Phone:		Cell Phon	ie:						
Job Status:	Email:											
Actions Following Incident: (please check all that apply)    Report Only   First Aid   Lost Time Injury   Saw/will see healthcare provider	Site:		Department:									
Report Only	Job Status: ☐Full Time ☐ Part Time ☐ Casual											
Name of healthcare provider/location  If your injury affects your ability to perform your full job duties/hours, have your healthcare provider complete a WRHA  Modified Duty Form (MDP) and return as instructed on the form.  DESCRIPTION OF INCIDENT:  Incident Date:	Actions Following Incid	ent: <i>(please cha</i>	eck all that apply)									
If your injury affects your ability to perform your full job duties/hours, have your healthcare provider complete a WRHA Modified Duty Form (MDF) and return as instructed on the form.  DESCRIPTION OF INCIDENT:  Incident Date: Day Month Year Incident Time: Dam Dpm  Location of Incident: I was in/at (complete all that apply)  Dite Interior: Building Name: Room/Area:  Diste Exterior: Le. parking lot It. parking lot Client's Address Street number, street name  Others involved in the incident: Patient Other Worker Family Member Dpublic 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: (attach another page if necessary)  Witness(es): no yes Name(s):  If related to patient/resident/client violent, aggressive or reactive behaviour complete the following  Occurrence Code White Called: no yes  Signature: Date: Day Month Year	Report Only Fir	st Aid 🔲 Lost 🤊	Time Injury 📮 Saw	v/will see health	ncare provider							
Modified Duty Form (MDF) and return as instructed on the form.  DESCRIPTION OF INCIDENT:  Incident Date:												
Incident Date:   Day   Month   Year   Incident Time:   Dam   Date:   Day   Month   Year   Incident Time:   Dam   Date:   Dat												
Incident Date:	Modified Duty Form (MDF) and return as instructed on the form.											
Location of Incident: I was in/at (complete all that apply)    Site Interior:   Building Name:	DESCRIPTION OF INCID	DENT:										
□ Site Interior: please be specific □ Site Exterior: i.e. parking lot □ Client's Address □ Street number, street name □ 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: (attach another page if necessary) □ Site Exterior: □ 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: (attach another page if necessary) □ Site Exterior: □ Incident: (attach another page if necessary) □ Site Exterior: □ Incident: (attach another page if necessary) □ Site Exterior: □ Incident: (attach another page if necessary) □ Site Exterior: □ Incident: (attach another page if necessary) □ Site Exterior: □ Incident: (attach another page if necessary) □ Site Exterior: □ Incident: (attach another page if necessary) □ Site Exterior: □ Incident: (attach another page if necessary) □ Site Exterior: □ Incident: (attach another page if necessary) □ Site Exterior: □ Incident: □ Incident: (attach another page if necessary) □ Site Exterior: □ Incident:	Incident Date: Da	y Month	n Year	Incident Time:	•	□am □p	m					
please be specific	Location of Incident: I	was in/at (comp	lete all that apply)									
□ Site Exterior: i.e. parking lot □ Client's Address Street number, street name 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: (attach another page if necessary)  Witness(es): □ no □yes Name(s): If related to patient/resident/client violent, aggressive or reactive behaviour complete the following  □ C.A.R.E. Screening Complete □ no □yes Code White Called: □ no □yes Signature of Employee Signature: □ Date: □ Day ■ Month Year	☐ Site Interior:	Building Name:										
□ Client's Address	please be specific											
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Code White Called: ☐ no ☐yes  Signature of Employee  Signature: Date: Day Month Year	If related to patient/res	sident/client viol	lent, aggressive or re	eactive behavio	ur complete the	following						
Code White Called: ☐ no ☐yes  Signature of Employee  Signature: Date: Day Month Year	C.A.R.F. Screening	Complete 🗖 no	o Dves	C.A.R.F. Alert Active \( \square\) no \( \square\) ves								
Signature of Employee Signature: Day Month Year		<b>'</b>	_,-,-									
Signature: Date: Day Month Year												
	. , ,			Date:	Dav	Month	Year					
	2.0		PLEASE COMPLE	l l	,							



WORK RELATED INJURY / NEAR MISS FORM											
Employee Name:						Incident Date:	Da	У	Month	Year	
PART OF BODY INJURED: (check all that apply)											
☐ Near Miss Report		☐ No Body Part Injured		☐ Psychological		☐ Verbal Abuse					
Head	□R		Neck	□R		Shoulder	□R		Hip(s)	□R	
Face	□R		Back-Upper	□R		Arm-Upper	□R		Leg-Upper	□R	
Eye(s)	□R		Back-Lower	□R		Arm-Lower	□R		Leg-Lower	□R	
Nose	□R		Back-Mid	□R		Elbow	□R		Knee	□R	
Mouth/Teeth	□R		Abdomen	□R		Wrist	□R		Ankle	□R	
Ear(s)	□R		Pelvis	□R		Hand	□R		Foot	□R	
Hearing	□R		Chest	□R		Finger(s)/Nails	□R		Toe(s)/Nails	□R	
☐ Other: please specify											
Comments:											
NATURE/TYPE OF INJURY: (check all that apply)											
Near Miss Report		No Body Part Injured		Psychological		Verbal Abuse					
Sprain/Strain			Foreign Objec	Foreign Object		Loss of Consciousness*			Follow Post Exposure		
	Pain Only		Chemical Exposure		Electrical Contact*		Protocol for the following				
Pain Only			Chemical Exp	osure		Electrical Contac	L		Protocor for th		0
Pain Only Bruise/Crush/	Abrasion		Dermatitis/Ra			Fracture/Disloca			Needlestick/Bio		
				ash							
Bruise/Crush/	n Minor		Dermatitis/Ra	ash cold/heat		Fracture/Disloca	tion*		Needlestick/Bio	ological	
Bruise/Crush/A	n Minor n requirin		Dermatitis/Ra Exposure to o	ash cold/heat /Deafness		Fracture/Disloca Amputation*	tion*		Needlestick/Bio Puncture	ological	
Bruise/Crush/ Cut/Laceration Cut/Laceration	n Minor n requirin		Dermatitis/Ra Exposure to d Hearing Loss	ash cold/heat /Deafness		Fracture/Disloca Amputation* Illness-Work Rel	tion*		Needlestick/Bid Puncture Blood/Body Flu	ological	
Bruise/Crush/ Cut/Laceration Cut/Laceration treatment at a	n Minor n requirin hospital*	<i>g</i>	Dermatitis/Ra Exposure to o Hearing Loss, Bite – Anima	ash cold/heat /Deafness I/Insect		Fracture/Disloca Amputation* Illness-Work Rel Specify:	tion*		Needlestick/Bio Puncture Blood/Body Flu Splash or Spill	ological	<u> </u>
Bruise/Crush/A Cut/Laceration Cut/Laceration treatment at A Burn/Scald	n Minor n requirin hospital*	<i>g</i>	Dermatitis/Ra Exposure to d Hearing Loss/ Bite – Anima Concussion	ash cold/heat /Deafness I/Insect		Fracture/Disloca Amputation* Illness-Work Rel Specify:	tion*		Needlestick/Bio Puncture Blood/Body Flu Splash or Spill	ological	<u> </u>
Bruise/Crush/. Cut/Laceration treatment at a Burn/Scald Burn - Third D	n Minor n requirin hospital* Degree *	<i>g</i>	Dermatitis/Ra Exposure to d Hearing Loss/ Bite – Anima Concussion	ash cold/heat /Deafness I/Insect		Fracture/Disloca Amputation* Illness-Work Rel Specify:	tion*		Needlestick/Bio Puncture Blood/Body Flu Splash or Spill	ological	<u> </u>
Bruise/Crush/A Cut/Laceration Cut/Laceration treatment at A Burn/Scald Burn - Third D Comments: *Serious Injury	n Minor n requirin hospital* Degree *	g G C C C C C C C C C C C C C	Dermatitis/Ra Exposure to of Hearing Loss, Bite – Anima Concussion  Other: plea	ash cold/heat /Deafness I/Insect ase specif		Fracture/Disloca Amputation* Illness-Work Rel Specify:	ated		Needlestick/Bio Puncture Blood/Body Flu Splash or Spill Bite – Human	ological	<u> </u>
Bruise/Crush/A Cut/Laceration Cut/Laceration treatment at A Burn/Scald Burn - Third D Comments: *Serious Injury	n Minor n requirin hospital* Degree * r – SEE BE REPORT	g G C C C C C C C C C C C C C	Dermatitis/Ra Exposure to or Hearing Loss, Bite – Anima Concussion Other: plea	ash cold/heat /Deafness I/Insect ase specif		Fracture/Disloca Amputation* Illness-Work Rel Specify: Infection	ated		Needlestick/Bio Puncture Blood/Body Flu Splash or Spill Bite – Human	ological	<u> </u>
Bruise/Crush/A Cut/Laceration treatment at a Burn/Scald Burn - Third D Comments: *Serious Injury	n Minor n requirin hospital* Degree * r – SEE BE REPORT	g D D ELOW	Dermatitis/Ra Exposure to or Hearing Loss, Bite – Anima Concussion Other: plea	ash cold/heat /Deafness I/Insect ase specif	U U U U U U U U U U U U U U U U U U U	Fracture/Disloca Amputation* Illness-Work Rel Specify: Infection	ated		Needlestick/Bio Puncture Blood/Body Flu Splash or Spill Bite – Human	ological	

## END OF EMPLOYEE REPORTING SECTION

## On duty Manager/Supervisor/Delegate must forward both pages immediately to OESH by email to <a href="INMintake@wrha.mb.ca">INMintake@wrha.mb.ca</a> or Fax 204-944-8417 DO NOT SEND via INTERDEPARTMENTAL MAIL. An investigation/corrective action form may 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 Italicized/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 Branch @ 204-945-3446 (regular working hours) or 204-945-0581 (after working hours). □yes – Name of Officer Contacted: Must be investigated by the Workplace Safety & Health Committee co-chairs or designates. ■ Notification to co-chairs Date: Patient Safety Event Reporting: through RL6 is also **IRIMS:** An IRIMS (security) report through RL6 is also required if the incident meets the criteria. \bullet yes required if the incident meets the criteria. □yes Incident # Incident # Critical Incident Stress Management (CISM) must be offered where a traumatic event falls beyond the usual range of human experience. The event does not have to meet the criteria of a Critical Incident or Critical Occurrence. These events can cause unusually strong emotional and stress reactions, which can overwhelm how a person copes. Please



consult the Operational Procedure on CISM.