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***

EMPLOYEE PERSONAL INFORMATION:

First Name:	Last Name:	Gender: ❑ Female ❑ Male
Work Phone:	Home Phone:	Cell Phone:
Email:		
Site:	Department:	Job Title:

Job Status: ❑Full Time ❑ Part Time ❑ Casual

Actions Following Incident: *(please check all that apply)*

❑ Report Only ❑ First Aid ❑ Lost Time Injury ❑ Saw/will see healthcare provider

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 (MDF) and return as instructed on the form.

DESCRIPTION OF INCIDENT:

Incident Date:	Day	Month	Year	Incident Time:	❑am ❑pm

Location of Incident: I was in/at (complete all that apply)

❑ Site Interior: *please be specific*	Building Name:	
	Floor/Wing:	Room/Area:
❑ 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	C.A.R.E. Alert Active ❑no ❑yes
Code White Called: ❑ no ❑yes	

Signature of Employee

Signature:	Date:	Day	Month	Year

PLEASE COMPLETE BOTH PAGES

WORK RELATED INJURY / NEAR MISS FORM

Employee Name:				Incident Date:	Day	Month	Year

PART OF BODY INJURED: *(check all that apply)*

❑ Near Miss Report			❑ No Body Part Injured			❑ Psychological			❑ Verbal Abuse		
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	Back-Mid	❑R	❑L	Elbow	❑R	❑L	Knee	❑R	❑L
Mouth/Teeth	❑R	❑L	Abdomen	❑R	❑L	Wrist	❑R	❑L	Ankle	❑R	❑L
Ear(s)	❑R	❑L	Pelvis	❑R	❑L	Hand	❑R	❑L	Foot	❑R	❑L
Hearing	❑R	❑L	Chest	❑R	❑L	Finger(s)/Nails	❑R	❑L	Toe(s)/Nails	❑R	❑L

❑ 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 Object ❑	*Loss of Consciousness** ❑	**Follow Post Exposure**
Pain Only ❑	Chemical Exposure ❑	*Electrical Contact** ❑	**Protocol for the following**
Bruise/Crush/Abrasion ❑	Dermatitis/Rash ❑	*Fracture/Dislocation** ❑	Needlestick/Biological
Cut/Laceration Minor ❑	Exposure to cold/heat ❑	*Amputation** ❑	Puncture ❑
*Cut/Laceration requiring treatment at hospital** ❑	Hearing Loss/Deafness ❑	Illness–Work Related ❑	Blood/Body Fluid
	Bite – Animal/Insect ❑	Specify:	Splash or Spill ❑
Burn/Scald ❑	Concussion ❑	Infection ❑	Bite – Human ❑
*Burn – Third Degree** ❑	❑ Other: *please specify*		

Comments:

**Serious Injury* – SEE BELOW*

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

INM Reported to	Full Name:			Position:
Report Date	Day	Month	Year	Report Time: ❑am ❑pm

END OF EMPLOYEE REPORTING SECTION

On duty Manager/Supervisor/Delegate

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/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 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. 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.