

INCIDENT REPORT FORM

 **To be completed within 24 hours of the incident (injury) date by:
 a) Students who do not report to a supervisor or manager (or designate)
 b) Visitors and contractors**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of individual involved in incident:** |  | **Student ID #:** |  |
| **City/Province where incident occurred:** |  | **Faculty of student:** |   |
| **Phone number of individual involved in incident that Health and Safety may contact you:** |  | **Occupation of contractor or visitor:** |  |
| **Email address of individual involved in incident that Health & Safety may contact you (if unable to reach you by phone):** |  |

Individual involved in incident:

: **Student** **Visitor Contractor**

 **Date of Incident:**

**Building Name/Location of Incident:** (whether ON or OFF campus)

**Time: am pm
Room #:**

**DESCRIBE HOW THE INCIDENT OCCURRED**
If more room is required, please attach a Word document to this Incident Report Form

**PLEASE PROVIDE DETAILS OF INJURY (illness if any) AS A RESULT OF THIS INCIDENT**(e.g. body part involved (include left or right), cut, strain, bruise, illness, symptoms, etc.):

1. **Was medical treatment received because of this incident (injury)?** **No** **Yes**

**If YES, please indicate type: Family Physician Hospital Clinic Other**

1. **Did this incident (injury) cause you to miss time from your studies or work AFTER the incident (injury) date?**

 **No** **Yes**

 i. What was the first day [DO NOT INCLUDE INCIDENT DATE] that you missed time from your studies or work?

 ii. Have you returned to your studies or work? No Yes

 If YES, what date?

 **3.** **Sign and date the completed Incident Report Form**. **Submit electronically to** **health.safety@uregina.ca**.

If you have any questions, please contact the Health & Safety Team (Human Resources) **Phone:** 306.337-2370 **Email:** health.safety@uregina.ca

**SIGNATURE:** **DATE:**

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