

This form is to be completed by the student/visitor/contractor involved in the incident/injury (where possible)  
 or designate within 24 hours of incident!

How to Complete the Incident Report Form:

**INCIDENT REPORT FORM**

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| --- | --- |
| **Student/Visitor/Contractor** | Complete the Incident Report Form below, sign and email to [health.safety@uregina.ca.](mailto:health.safety@uregina.ca) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Individual Involved in incident:** |  | **Student ID #:** |  |
| **Address:** |  | **Job Title** | If applicable |
| **City/Province/Postal Code** |  | **Department/Faculty:** |  |
| **Primary phone:** |  | | |
| **Work phone:** |  | | |

Are You:

Student Visitor

Contractor

**Date of Incident:**

**Building Name:** (Building name ON or OFF Campus)

**Time: am pm Room #:**

**Please describe how the incident occurred. If more room is required, please attach a Word document to this report):**

**Please provide details of injury/illness, if any - (e.g. body part involved, 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 work and/or your studies **AFTER** the incident (injury) date?  
   No Yes

If you answered NO, GO TO SIGNATURE LINE Sign and date Incident Report and submit to [health.safety@uregina.ca](mailto:health.safety@uregina.ca) immediately.

If you answered YES, complete section below Sign and date Incident Report and submit to [health.safety@uregina.ca](mailto:health.safety@uregina.ca) immediately.

1. What was the first date **(DO NOT INCLUDE INCIDENT DATE** you missed work or time from your studies?

1. Have you returned to work or your studies?  No  Yes  
     
   If Yes, what date did you return?

Signature: Date:

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