SAINT MARY'S UNIVERSITY SINCE 1802 One University. One World. Yours. Please specify if the following report is an

Health and Safety Injury/Incident Report (Please print, sign, and return completed hard-copy to the Occupational Health and Safety Office)

() Incident

() Injury

() Near Miss

Faculty, Staff or Student Involved in the Injury/Incident/Near Miss														
Surname:				Given Name: Con						ntact N	tact Number:			
Please circle one:	SMU E1	mploy	ree S	Student (including SMU student employee) Oth						ther/Vis	er/Visitor (explain)			
Employee/Student I	I	Department/Program:												
Witness 1														
Surname:	(Given Name: Contact Number:												
<u>_</u>														
	SMU E	mploy	ree S	Student (including SMU student employee) O						ner/Visitor (explain)				
Witness 2														
Surname:		(Given Name:				Co	Contact Number:						
Please circle one:	cle one: SMU Employee					t (including SMU student employee)) Ot	Other/Visitor (explain)				
Injury/Incident/Near Miss Information														
Date and Time:			am	Location of the Injury/Incident/Near Miss:										
	pm													
Reported by:														
Description of Injury/Incident/Near Miss (Please describe exactly what happened and attach any pages including														
diagrams/pictures if necessary):														
D " "11			C 1	1.	1	., 1	1 7	· /T	. 1					
Describe any possible precipitating factors that directly contributed to the Injury/Incident:														
Describe any persona	al iniury	or pro	perty/ea	uiome	nt dam	nage which oc	curre	ed due to	o the I	niury/In	cident:			
Describe any persona		01 P10	pperey/eq	onp in c	are causes		, , ,	ou duo t	0 110 1	.1) (41) / 111	.c.acii			
Prevention: Are there	any prov	entati	ve actions	e which	a coule	the put in pla	ace to	nreven	t an ini	ury /inc	ident like t	his to re	-000112	
Employee:	any picv	Ciitati	ve actions	5 WIIIC	i couic	i be put in piz	acc ii	pieven	t all III ₎	ury / mc	idelit like t	1115 10 10	-occur:	
Employee.														
Supervisor:														
Supervisor.														
										1				
Form Submitted by:								Date						
Reviewed by Direct S		urred please complete the following section						Date:						
Carra of Initia	11 :	an In	jury nas o	occuri	ea pie	ease complet	e tne	е топом	ing se	ction				
Cause of Injury Slips/Trips/Falls ()	Sho	clr /So	izure ()	Or.	or Eve	ertion/Strain	()	Harmfu	1 Suba	anco/LI	armful Ex	2001140	1	
Struck by Object ()		known			her ()	(explain):		Tammu	ıı Subsi	lance/11	ammu Ex	posure ()	
If Applicable Please			()		iici ()	(схріані).								
Head () Eyes ()	y IIIC	Face (Neck/	Shoulders ()) (Chest ()		Arms	s() Ha	nds ()		
Abdomen/Stomach	() Le	egs ()	Feet (,		Back ()		Lower Ba	ack ()		nal Injuries	\ /		
Other () (explain):	() 13.	8 ()	, 1 000 (/	oppor	zuen ()		30 11 62 23.	()	111001	1101 111)01100	/ ()		
Emergency Medica	ıl Attent	tion												
911 Called			First Aid	Given	Yes () By whom:						No ()			
Sent to Hospital	_		Transpor							cle () Other ()				
Referred to EAP						ounselling	Yes							
Treated by														
University Health Ser			No (O:	n cam	\ D1			c Yes	No	Family	Doctor	Yes	No	
Occupational Health and Safety Office Use Only												1 05		
1 , , , , , , , , , , , , , , , , , , ,														
WCB Coverage				Jse O1	nly	hysiotherapy	Clini	c Tes	1110		Doctor	105		

THIS INFORMATION IS COLLECTED FOR THE PURPOSE OF THE SAINT MARY'S OCCUPATIONAL HEALTH AND SAFETY COMMITTEE

7/15/2008 /ms