

All forms are to remain on file in the Office of the Director, Facilities Management.

Submit this form to the Director, Facilities Management

Date of Incident: _____ Time of Incident: _____

Reported by: _____

Dept.: _____ Dept. Head: _____

Near Miss Safety Issue Accident

Name of Individual: _____

Nature of Incident:

Witness(es) Name(s): _____

Witness Statement (use separate page if necessary): _____

Location of Incident: _____ Room No. _____

Time of Incident: _____ Condition of Area: _____

Employee's Account of Incident: _____

Medical Attention Required: Yes No Work days Lost: Yes No

Length of time prior to seeking medical attention: _____

Nature of Medical Attention:

Was Person Taken to Hospital? Yes No How? _____

Which Hospital? _____ Accompanied? _____

Photograph of area or diagram of incident site:

Hazardous Conditions Present - describe?

Safety Rules Applied? Yes No

Recommendations for Prevention: _____

Date: _____ Time _____ Signed: _____

Actions Taken by Facilities Management:

Date: _____ Time _____ By Whom _____

Date Presented to Occupational Health and Safety:

Further Action Required? Yes _____ No _____

Nature of Further Action Required:

Completion Date: _____ By Whom _____

Cc Director of Human Resources
Chair/Director/VP of area