Accident and Incident Reporting

ComField Property Management

All accidents and incidents must be reported within 24 hours to Fax line: 416-932-2670 or emailed to: jenniferb@cfdi.ca

Please attach any applicable documents to the back (ie: police report, pictures, statements)

O Employee **O Tenant/Member** **O Visitor**

Date of Accident/Incident: _____Time of Accident/Incident: _____AM☐PM☐

Name: _____ Address:_____

Phone Number: _____Alternate Number: _____

Location of Accident or Incident: _____

_____

Date Supervisor notified: _____Time: _____AM☐PM☐

Please provide details of Accident/Incident or Harassment: (more space is available on page 3)

_____

_____

_____

_____

DETAILS:

1. Was the accident/illness:

☐ Sudden Specific Event/Occurrence
☐ Gradually Occurring Over
☐ Occupational Disease
☐ Fatality

2. Type of accident/illness: (Please check all that apply)

☐ Struck/Caught
☐ Overexertion
☐ Repetition
☐ Fire/Explosion

☐ Fall
☐ Harmful Subs/Environmental
☐ Assault
☐ Other_____

☐ Slip/Trip
☐ Vehicle

3. Area of Injury (Body Part) – (Please check all that apply)

☐ Head
☐ Face
☐ Eyes
☐ Ear (s)

☐ Teeth
☐ Neck
☐ Chest
☐ Pelvis

☐ Upper Back
☐ Lower Back
☐ Abdomen
☐ Other _____

	L	R
Shoulder	☐	☐
Arm	☐	☐
Elbow	☐	☐
Forearm	☐	☐

	L	R
Wrist	☐	☐
Hand	☐	☐
Finger(s)	☐	☐

	L	R
Hip	☐	☐
Thigh	☐	☐
Knee	☐	☐
Lwr/Leg	☐	☐

	L	R
Ankle	☐	☐
Foot	☐	☐
Toe(s)	☐	☐

HEALTH CARE DETAILS:

1. Did the person receive health care for this injury? ☐ Yes ☐ No - **If YES, specify date** _____ _____
2. When did CFDI Management learn that the person received health care? Specify date_____ ___ _____
3. Where was the person treated for this injury (please check all that apply below):

☐ On-site First Aid
☐ Clinic

☐ Ambulance
☐ Admitted to Hospital

☐ Health Professional Office
☐ Other: _____

Name, address and phone number of health professional or facility who treated this worker (if known)

_____

_____

OTHER PARTY INVOLVED (if applicable):

Name: _____

Address: _____

Telephone #: _____ Alternate Number: _____

Relationship to injured person:_____

Police Report # (Attach if applicable): _____

WITNESS (If applicable)

Witness: _____ Phone #: _____

Witness: _____ Phone #: _____

PROPERTY/DAMAGED EQUIPMENT (If applicable):

Property/Damaged Equipment: _____Est. Cost: _____

Description of Damage: _____

_____

_____

EMPLOYEE SECTION ONLY

LOST TIME/NO LOST TIME (please choose one of the following)

☐ Returned to his/her regular job and has **not** lost any time and/or earnings.
☐ Returned to modified work and has **not** lost any time and/or earnings.
☐ Has lost time and/or earnings.
IF LOST TIME – Date: _____Date worker returned:_____ ☐ Regular work ☐ Modified work

As a progressive Management Company, Community First Developments Inc. and ComField Property Management offers a modified work program for injured employees. Please speak to your HR Representative for further information if, as a result of accident or injury, regular duties cannot be performed for any period of time.

PLEASE SIGN OFF BELOW & CONTINUE TO NEXT TWO PAGES

Signature: _____ **Date:** _____

Immediate Supervisor: _____ **Date:** _____

Department Manager: _____ **Date:**_____

More details: Please draw what you see, or take a picture. You may also use the below space to record more information, statements etc.

Accident Investigation Report

This must be completed by the on site manager or senior manager

DATE AND TIME INVESTIGATION BEGAN:
WAS THERE ANYTHING UNUSUAL ABOUT THE ACTIVITY OF THE INDIVIDUAL THAT COULD HAVE CONTRIBUTED TO THE ACCIDENT? (IE: IMPROPER FOOTWEAR, RUNNING ON WET FLOORS, IMPROPER LIFTING)
WERE ESTABLISHED RULES, REGULATIONS AND PROCEDURES BEING FOLLOWED? (IE: PERSONAL PROTECTIVE EQUIPMENT WORN?
WHAT COULD BE DONE TO PREVENT A SIMILAR ACCIDENT FROM OCCURRING?
WHAT CORRECTIVE ACTION HAS ALREADY BEEN COMPLETED?
WHAT CORRECTIVE ACTION IS PLANNED?
CORRECTIVE ACTION COMPLETE? □ YES □ NO COMPLETED BY: DATE:

PREPARED BY:	**DATE:**
REVIEWED BY:	**DATE:**

FOR OFFICE USE ONLY: **INSURANCE COMPANY: YES OR NO**

WSIB: YES OR NO

LOST TIME: YES OR NO **REVIEWED: _____**

IF ANY LOST TIME, # OF DAYS: _____