



OHS PROGRAM - INCIDENT INVESTIGATION & REPORTING				
Form #: 03-19	Created: July 2025	Last rev:	Rev. 1.1	1 of 3

Section 1 - Employer Information (complete for ALL employers when applicable)

Employer #1 Legal Name:	WSBC Account #:
Head Office Address:	
Employer's Representative's name & Contacts:	
Employer # 2 Legal Name:	WSBC Account #:
Head Office Address:	
Employer's Representative's name & Contacts:	
Employer #3 Legal Name:	WSBC Account #:
Head Office Address:	
Employer's Representative's name & Contacts:	

Section 2 - Incident/Investigation Information

Project:	Address:			
Person(s) Conducting Investigation:				
Person Writing this Report:	Contact:			
Date/Time of Incident:	Contact:			
Location on site:				
<input type="checkbox"/> offsite:				
<input type="checkbox"/> other:				
Report Stage:	<input type="checkbox"/> Preliminary Date:	<input type="checkbox"/> Interim Date:	<input type="checkbox"/> Full Date:	<input type="checkbox"/> Completed Date:

Section 3 - Description of the incident

Type of Incident (select all that apply) This incident was a near miss

<input type="checkbox"/> Injury/Illness	<input type="checkbox"/> Major injury/illness	<input type="checkbox"/> Fire/explosion
<input type="checkbox"/> Material/equipment damage	<input type="checkbox"/> Private Property damage	<input type="checkbox"/> Public Property damage
<input type="checkbox"/> Environmental damage	<input type="checkbox"/> Security breached	<input type="checkbox"/> Complaint
<input type="checkbox"/> Chemical spill/release	<input type="checkbox"/> Public interaction/MVA	<input type="checkbox"/> Other:

Does WorkSafeBC or other regulatory bodies require notification of such incident? Yes – done on: No

Injured worker(s) this section is n/a

Name:	Employer:	Contact:	Status: <input type="checkbox"/> FA <input type="checkbox"/> MI <input type="checkbox"/> Fatality
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Name:	Employer:	Contact:	Status: <input type="checkbox"/> FA <input type="checkbox"/> MI <input type="checkbox"/> Fatality

Others involved (e.g. eye witnesses, first aid attendant, direct supervisor, person reporting the incident, etc.) this section is n/a

Name:	Employer:	Contact:	Relation:
Name:	Employer:	Contact:	Relation:
Name:	Employer:	Contact:	Relation:

Description of the incident (Describe what happened before and during the incident. Use chronological order and add time of events if known)



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Injury outcome: RTW Same day MA without LT MA with LT Orders

Section 4 – Preliminary Investigation - To be completed within 48 hours of incident occurrence

attach additional pages if required, make sure all pages are numbered

Interim Corrective Actions taken during & after Preliminary Investigation (select all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Scene of incident secured | <input type="checkbox"/> First Aid / Medical Aid | <input type="checkbox"/> Material/equipment secured |
| <input type="checkbox"/> Energy flow stopped | <input type="checkbox"/> Site evacuation (ERP invoked) | <input type="checkbox"/> Property damage mitigated/limited |
| <input type="checkbox"/> Fire extinguished/controlled | <input type="checkbox"/> Rescue attempt (as per SJP) | <input type="checkbox"/> Other: |

Description of <u>interim</u> corrective action(s)	Due date	By whom	Completion date

Other actions taken/agencies contacted (select all that apply, indicate time when external agencies were contacted)

- | | | |
|--|---|---|
| <input type="checkbox"/> Worker statements | <input type="checkbox"/> Police (non-emerg.): _____ | <input type="checkbox"/> Fire (non-emerg.): _____ |
| <input type="checkbox"/> Witness statements | <input type="checkbox"/> Ambulance/911: _____ | <input type="checkbox"/> WSBC (1-888-621-7233): _____ |
| <input type="checkbox"/> Pictures/sketches of incident | <input type="checkbox"/> Equipment/material secured | <input type="checkbox"/> Utility: <input type="checkbox"/> BCHydro <input type="checkbox"/> Fortis <input type="checkbox"/> Municipal |
| <input type="checkbox"/> Work stoppage | <input type="checkbox"/> Incident investigation started | <input type="checkbox"/> Other agency: _____ |

Section 5 – Full Investigation - To be completed within 30 days of incident occurrence

Root (Underlying) Causes (why the OHS management system failed to prevent the accident)



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Final Corrective Action(s) to prevent reoccurrence (after Full Investigation is completed)			
Description of Final corrective action(s)	Due date	By whom	Completion date

Section 6 – Review

Injured / Involved Worker's Direct Supervisor (Add comments if any, print name & Sign)

Name: _____ Signature: _____

JOHS Committee / Worker Representative (Add comments if any, print name & Sign)

Name: _____ Signature: _____

Employer Representative/Manager (Add comments if any, print name & Sign)

Name: _____ Signature: _____

Safety Coordinator / Manager / Consultant (Add comments if any, print name & Sign)

Name: _____ Signature: _____

Site Superintendent Review Where Applicable (Add comments if any, print name & Sign)

Name: _____ Signature: _____