

This form must be completed by an NBCC employee immediately following an injury or incident and before voluntarily leaving the workplace. Instructors are responsible to complete this form on behalf of their students. For details on reporting requirements, please refer to the [Injury Incident Reporting Guidelines](#).

Submission Options:

1. Service Desk Ticket: Open [NBCC Fresh Service](#) > Select 1. [Request a Service](#) 2. [Health and Safety](#) 3. [Report an Injury or Incident](#). Once submitted, the ticket will automatically be sent to the Facilities Manager and Manager- Health & Safety.
2. Email: Submit this form as an attachment to the Facilities Manager and copy (cc) Health&Safety@nbcc.ca
3. In-person: Submit a hard copy of this form to the Facilities Manager

General Information

Injury type:

- | | |
|--|--|
| <input type="checkbox"/> Allergic reaction | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Heart or stroke |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Infectious disease |
| <input type="checkbox"/> Chemical exposure | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Cut, laceration, abrasion | <input type="checkbox"/> Loss of hearing |
| <input type="checkbox"/> Fatality | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Fracture | |
| <input type="checkbox"/> Other: | |

Incident type:

- | |
|---|
| <input type="checkbox"/> Equipment failure |
| <input type="checkbox"/> Fire or explosion |
| <input type="checkbox"/> Near miss |
| <input type="checkbox"/> Property damage |
| <input type="checkbox"/> Theft |
| <input type="checkbox"/> Threat or violence |
| <input type="checkbox"/> Vehicle related |
| <input type="checkbox"/> Other: |

Date of injury or incident:

Name of affected person:

Department/Program:

Classification:

Building:

Treatment received:

Witnesses:

Time of injury or incident:

Occupation:

Manager's name:

Campus or site:

Area or Room:

Detailed Information

If injured, indicate affected body part:

- | | | | |
|----------------------------------|------------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Eye | <input type="checkbox"/> Hip | <input type="checkbox"/> Ribs |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Face | <input type="checkbox"/> Jaw | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Finger(s) | <input type="checkbox"/> Knee | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Back | <input type="checkbox"/> Foot | <input type="checkbox"/> Leg | <input type="checkbox"/> Teeth |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Groin | <input type="checkbox"/> Mouth | <input type="checkbox"/> Toe(s) |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Hands | <input type="checkbox"/> Neck | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Head | <input type="checkbox"/> Nose | |
| <input type="checkbox"/> Other: | | | |

Contributing factors:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Defective equipment | <input type="checkbox"/> Insufficient care or attention | <input type="checkbox"/> Insufficient training | <input type="checkbox"/> Violation – safe work practice |
| <input type="checkbox"/> Other: | | | |

Injury Incident Report Form

Provide a detailed description of the injury or incident:

What safeguards or preventions are normally used?

What actions have been taken to prevent reoccurrence?

Additional information:

Compensation Benefits

Completion of the [WorkSafeNB Application for Workers' Compensation Benefits](#) form is required when an individual seeks benefits related to a work-related injury or illness under one or both of the following conditions:

1. The individual has been absent from work beyond the date of injury or illness;
2. The individual has received medical care exceeding standard first aid, provided by a licensed health care professional.

Is the individual applying for benefits?

Date submitted to WorkSafeNB:

Signature of person reporting the injury or incident:

WorksafeNB Reporting Requirements

Notify WorkSafeNB immediately by calling 1-800-999-9775 to report the following incidents:

- A loss of consciousness
- Amputations
- Fractures (other than fingers or toes)
- Burns requiring medical attention beyond first aid treatment
- Loss of vision in one or both eyes
- Deep lacerations requiring medical attention beyond first treatment
- Worker admission to a hospital as an in-patient
- Fatalities
- Any accidental explosion to a biological, chemical or physical agent, whether or not a person is injured
- Any catastrophic event or equipment failure that results or could have resulted in an injury

For additional details, refer to the [OHS Guide](#)