

General Injury/Incident Report Form

Employers have a legal obligation to provide a mechanism for reporting injuries and other harmful workplace occurrences, and to investigate or otherwise respond appropriately. These obligations may vary per province and the size of the business.

Where the employer has defined a process and format for reporting, please use theirs.

In case of a critical injury (fatality, significant loss of blood, fracture of a limb, unconsciousness, etc.), provide immediately necessary first aid and call for medical assistance, notify your supervisor immediately, and secure the site of the incident to prevent further injury and to preserve it for investigation.

Important: Equity makes no representation that this generic report form will meet legal obligations for the employer. It is provided for member convenience only, for situations where no other reporting mechanism is immediately available. Additional forms may be required to report the occurrence for worker's compensation, Equity's insurance, etc.

THE INCIDENT	
Reported by	Department
Email	Phone
Date and time of occurrence	Date first reported and reason for delay (if not reported at time of occurrence)
Location of occurrence	
Was it? <input type="checkbox"/> An injury <input type="checkbox"/> A close call <input type="checkbox"/> Inappropriate behaviour <input type="checkbox"/> Violence <input type="checkbox"/> Sickness <input type="checkbox"/> Other (please specify)	

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What happened? Identify anything that may have contributed to the incident (e.g. poor lighting, sharp edge, unguarded drop, etc.). Attach additional pages if necessary.

What was the result of the incident? (e.g. injury/other health effects/damage)

What corrective measures were taken to address any immediate hazards related to incident?

Are there any further recommendations to prevent the same, or similar, incident from occurring again?

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PERSON(S) AFFECTED	
Name(s) – attach additional pages if necessary.	Position (worker, guest, etc.)
Phone	Email
Address (if available)	Employer and employer contact information (if not the engager)

WITNESS DETAILS	
Name and contact information	Name and contact information

FIRST AID AND MEDICAL ATTENTION
Was first aid and/or professional medical attention provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
By whom: Details of first aid or medical attention:
Time of arrival of first aid or medical assistance (if not present for occurrence):
Contact information for any outside medical assistance received:

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AFTER THE INCIDENT

Where did the person involved in the incident go next?

- ☐ To the hospital ☐ Home ☐ Returned to work
☐ Other (please specify)

Who received a copy of this report? (Please retain a copy for yourself)

- ☐ Executive Director/GM ☐ Human Resources ☐ Production Manager
☐ Technical Director ☐ Production Stage Manager ☐ Affected persons
☐ Supervisor or Other (please specify)

Additional notes: