

Accidental Event Declaration Form

1 Identification of the employee who was a victim of the accidental event

Please write clearly (print) and answer all the questions

Do not hesitate to ask your supervisor or union representative to help you

Last name: _____ First name: _____
Employee number: _____ Job title: _____
Telephone number: _____ Department: _____
Institution: _____ Location: _____

2 Employee's description of the accidental event

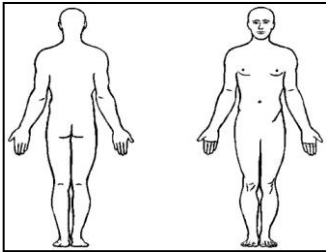
Date of the event: _____ (yyyy - mm - dd) Time of the event: _____ (00:00 am/pm)

First aid received? Yes No Shift completed? Yes No

Exact place of the event (E.g.: location, room, floor): _____

Names of people present during the event: _____

Indicate the area of the injury or pain on the diagram and check off the details of the event below:



Aggression: physical verbal
Splatter: biological chemical
Excessive effort: with a user with an object
Fall/Slip Defective equipment Cut
Needle-stick/bite Other: _____

Describe the circumstances surrounding the event:

Corrective measure(s) to introduce: _____

Employee's signature: _____ Date (yyyy-mm-dd): _____

3 Section reserved for the immediate supervisor

Date on which the worker told you about the event (yyyy-mm-dd): _____

Work situation anomalies in the following components:

Individual (worker): _____ Individual (user): _____

Equipment - materiel - product: _____ Task: _____

Time: _____ Environment: _____

Organization of work: _____

Other comments: _____

Do you agree with the description of the event? Yes No

Request for corrective measure(s): Yes Proposed measure: _____ No

Responsible for corrective measure(s) (Deadline (yyyy-mm-dd)): _____

Last name, First name of the immediate supervisor

Signature of the immediate supervisor

Date (yyyy-mm-dd)

Please send this form to the Workplace Health, Safety and Well-Being Directorate as soon as possible

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