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## SECTION 1: NOTICE OF INJURY (SKIP TO SECTION 2 FOR NON-INJURY RELATED INCIDENTS)

This form needs to be completed for all injuries. Worker's Compensation Employee and Employer Reports should be completed for incidents requiring medical assistance or time loss. Employees may call 204-954-4100 to report a claim to the WCB. Forms are located online: [http://umanitoba.ca/admin/vp\\_admin/risk\\_management/ehso/occ\\_health\\_comp/aiwcb.html](http://umanitoba.ca/admin/vp_admin/risk_management/ehso/occ_health_comp/aiwcb.html)

Name of Injured Person:  Phone:

Date of Injury:  Location:  Time:  a.m. p.m.

Witness Name:  Phone:

Name of the Person completing this Form if not the Injured Person:  Phone:

Cause of Injury/What was injured? (Please note left or right, if applicable).

What were you (the Injured Person) doing at the time of Injury?

Did you (the Injured Person) report the accident immediately? \_\_\_\_\_ To Whom: \_\_\_\_\_

If not, what was your reason?

Was Security Services contacted? Yes \_\_\_ No \_\_\_ Was Winnipeg Fire Paramedic Service contacted? Yes \_\_\_ No \_\_\_

Was treatment provided by staff? Yes \_\_\_ No \_\_\_ Was Injured Person transported to hospital? Yes \_\_\_ No \_\_\_

COMPLETE FOR EMPLOYEE INJURY:

Department: \_\_\_\_\_ Supervisor Phone: \_\_\_\_\_

Have you seen or do you plan to see a doctor? Yes No  
(If you miss work due to an accident, you must see a doctor on the first day you miss work and provide medical updates until you return to work)

Name and Address of Doctor: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_ Signature of Supervisor: \_\_\_\_\_

Signature of Injured/Involved Person: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION 2: NOTICE OF INCIDENT

**(Form to be completed for all non-injury related incidents. For injuries, please fill out Section I, Notice of Injury.)**

(1) Name of Individual Involved:  Phone:

(2) Name of Individual Involved:  Phone:

Date of Incident:  Location:  Time:  a.m. p.m.

Witness Name:  Phone:

Name of the person completing this form if not the person involved:  Phone:

Was Security Services contacted? Yes  No  Was Winnipeg Fire Paramedic Service contacted? Yes  No

Describe the incident that occurred in detail:

Follow-up after the incident: Date: \_\_\_\_\_ Staff person who followed-up: \_\_\_\_\_

**DISTRIBUTION:** This completed form must be given immediately to the direct Supervisor of the employee or area in which the incident occurred; and for distribution as follows:

Supervisor –original (file for possible future reference)

Security Services Report No. \_\_\_\_\_

Cc to Employee – copy (injuries only)

Cc to Unit Director/Manager – copy

Cc to EHS – copy

Cc to Director of Facilities – copy

Cc to Director of Security Services – copy (incidents only)

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### Notice Regarding Collection, Use, and Disclosure of Personal Information and Personal Health Information by the University

Your personal information and personal health information is being collected under the authority of The University of Manitoba Act. The information you provide will be used by the University to track all injuries that occur at the University, to determine if a Workers Compensation Board claim is required, and for communication. Your personal information and personal health information may be disclosed to the Worker's Compensation Board in the event of a WCB claim. Your personal information and personal health information will not be used or disclosed for other purposes, unless permitted by The Personal Health Information Act (PHIA) or The Freedom of Information and Protection of Privacy Act (FIPPA). If you have any questions about the collection of your personal information or personal health information, contact the Access & Privacy Office (tel. 204-474-9462), 233 Elizabeth Dafoe Library, University of Manitoba, Winnipeg, MB, R3T 2N2.