School District # 64 Report of a Near Miss

This is an SD 64 form for reporting near miss incidents
Please note that this form is not a Worksafe form but an alternative way for recording information
Notify your supervisor of this report immediately, then copy and send to SD64 Joint Health and Safety Committee

Worker last name	First name	Middle initial	Work Location
	Maintenance Action Needed Yes ☐ No ☐		Student Services Action Needed Yes ☐ No ☐

Incident information

Date and time of incident (yyyy-mm-dd) a.m. ☐ p.m ☐	Period of exposure resulting in occupational disease(yyyy-mm-dd)
Have you reported the injury/exposure to your employer? Yes ☐ No ☐	The injury or disease was first reported to (please check one) First aid ☐ Supervisor ☐ Office ☐ Other ☐
Name of person reported to	Date injury or disease was reported (yyyy-mm-dd)
If no, provide reason for not reporting to your employer	
Describe how the incident happened	Describe the injury in detail (what part of the body was injured)
	Side of body injured Left ☐ Right ☐ Both ☐ Not applicable ☐
Describe the work incident location (address, city, provinc) and where incident occurred (e.g. shop floor, lunchroom, parking lot)	
Did your injury(ies) or exposure result from a specific incident? Yes ☐ No ☐	

Contributing factors-select AT LEAST ONE, and as many as applicable Lifting _____ lb ☐ kg ☐

Overexertion	☐	Struck	☐
Repetitive(activity repeated over and over again)	☐	Crush	☐
Slip or trip	☐	Sharp edge	☐
Twist	☐	Fire or explosion	☐
Fall	☐	Harmful substance in the work environment	☐

Were there any witnesses? Yes ☐ No ☐	Did the incident occur in British Columbia? Yes ☐ No ☐
Were your actions at time of injury for your employer's business? Yes ☐ No ☐	Did the incident occur on employer's premises or an authorized worksite? Yes ☐ No ☐
Did the incident occur during your normal shift? Yes ☐ No ☐	Were you performing your regular work duties at the time of the incident? Yes ☐ No ☐
Did you receive first aid? Yes ☐ No ☐	If yes, please provide first aid attendant name (if known)
Did you go to hospital, clinic, or visit a physician or qualified practitioner? Yes ☐ No ☐	If yes, please provide provider name (if known)
If yes, please provide provider address(if known)	
Prior to this incident, did you have any recent pain or disability in the area of your injury? Yes ☐ No ☐	

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Supervisor: email completed form to mailto:ohs@sd64.org

Information about your employment

Type of business	Address	City	Province	Postal Code
Educational 765008	112 Rainbow Road	Salt Spring Island	BC	V8K 2K3

Operation location	Employer contact last name	First name	Employer phone number	Extension
School District 64 (Gulf Islands)	George	Cathy	250 537 5548	211

What is your occupation?

Have you been employed by this firm for less than 12 months Yes ☐ No ☐

3. If yes, start date (yyyy-mm-dd)

4. At the time of injury, were you (please check all that apply)

Permanent ☐	Apprentice ☐	Self-employed ☐	Casual ☐
Temporary ☐	Volunteer ☐	Hired on a contract basis ☐	Other (please specify) ☐
Full Time ☐	Student ☐		
Part Time ☐	New entrant to workforce ☐		

5. Any other pertinent information?

For Office Use Only - Response Portion

Does an Investigation need to be completed? Yes ☐ No ☐ If no, explain why:

Does a Work Order need to be entered for a repair? Yes ☐ No ☐ If no, explain why:

Work Order Details :

Work Order Number:

**Be sure to enter in EBASE