

This is an SD 64 form for reporting minor injuries and 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 <input type="checkbox"/> No <input type="checkbox"/>	Student Services Action Needed
		Yes <input type="checkbox"/> No <input type="checkbox"/>	

Incident information

Date and time of incident (yyyy-mm-dd) a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Period of exposure resulting in occupational disease(yyyy-mm-dd)
Have you reported the injury/exposure to your employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	The injury or disease was first reported to (please check one) First aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Other <input type="checkbox"/>
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 <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	
Contributing factors-select AT LEAST ONE, and as many as applicable	
Lifting <input type="checkbox"/> _____ lb <input type="checkbox"/> kg <input type="checkbox"/>	
Overexertion <input type="checkbox"/>	Struck <input type="checkbox"/>
Repetitive(activity repeated over and over again) <input type="checkbox"/>	Crush <input type="checkbox"/>
Slip or trip <input type="checkbox"/>	Sharp edge <input type="checkbox"/>
Twist <input type="checkbox"/>	Fire or explosion <input type="checkbox"/>
Fall <input type="checkbox"/>	Harmful substance in the work environment <input type="checkbox"/>
Were there any witnesses? Yes <input type="checkbox"/> No <input type="checkbox"/>	Did the incident occur in British Columbia? Yes <input type="checkbox"/> No <input type="checkbox"/>
Were your actions at time of injury for your employer's business? Yes <input type="checkbox"/> No <input type="checkbox"/>	Did the incident occur on employer's premises or an authorized worksite? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did the incident occur during your normal shift? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were you performing your regular work duties at the time of the incident? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you receive first aid? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please provide first aid attendant name (if known)
Did you go to hospital, clinic, or visit a physician or qualified practitioner? Yes <input type="checkbox"/> No <input type="checkbox"/>	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 <input type="checkbox"/> No <input type="checkbox"/>	

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Information about your employment

Type of business Educational 765008	Address 112 Rainbow Road	City Salt Spring Island	Province BC	Postal Code V8K 2K3
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Operation location School District 64 (Gulf Islands)	Employer contact last name George	First name Cathy	Employer phone number 250 537 5548	Extension 211
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What is your occupation?	Have you been employed by this firm for less than 12 months Yes <input type="checkbox"/> No <input type="checkbox"/>	3. If yes, start date (yyyy-mm-dd)
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4. At the time of injury, were you (please check all that apply)

Permanent <input type="checkbox"/>	Apprentice <input type="checkbox"/>	Self-employed <input type="checkbox"/>	Casual <input type="checkbox"/>
Temporary <input type="checkbox"/>	Volunteer <input type="checkbox"/>	Hired on a contract basis <input type="checkbox"/>	Other (please specify) <input type="checkbox"/>
Full Time <input type="checkbox"/>	Student <input type="checkbox"/>		
Part Time <input type="checkbox"/>	New entrant to workforce <input type="checkbox"/>		

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 mark the Work Order as Health and Safety in the Priority drop down menu.****