**Instructions**

All accidents must be reported and investigated. Supervisors (Lieutenants, Captains & other supervisors) must complete this form and immediately contact an investigator. The immediate supervisor must complete this report immediately after the accident or near miss. In the absence of a supervisor the person having the accident should, if they are able, complete this form. The report must be submitted before the end of shift (career) or before leaving the fire station (volunteer).

This report has five parts. Everything you need to report a workplace accident, injury or near miss is included. You may check "not applicable" for parts that do not apply:
PART 1 – Who is reporting this accident or near miss? (must always be completed)
PART 2 – What happened? (must always be completed)
PART 3 – Injury Report
PART 4 – Motor Vehicle Collision Report
PART 5 – Exposure Report

Fill in all the applicable sections. Call your District Captain, Division Commander, Station Chief or other Supervisor to inform them of the accident so they may start an investigation. Email a copy of this report immediately to fsdiv@halifax.ca. If you don't have access to email, fax a copy to 902-490-7114. Sign your report and give the signed original to your District Captain, Division Commander, Station Chief or other Supervisor.

If this accident resulted in serious injury, call dispatch and request them to notify the District Captain, Divisional Commander, and Divisional Chief of Safety immediately.
At the accident scene:

- provide medical treatment for all injured persons.
- secure the scene to prevent further injury.
- protect the scene and evidence.
- keep witnesses at the scene for the investigator. If they refuse, record their names and contact information.
- Do not disturb the scene until internal and external investigators have approved.

| **PART 1 – Who is reporting this accident or near miss?** | |
|---|---|
| Date of the accident? | Time? |
| Where did this happen? ? | |
| Work location and shift? ? | FDM Incident #? *(if applicable)* |
| Officer or person reporting this? *(print/type)* | |
| Your telephone #? | Date of this report? |
| Who is your supervisor? ? | |
| Who did you call to investigate this? (District Captain, Chief or other Supervisor) ? | |
| Signature: ? | |

## PART 2 – What happened?

What type of incident was this? *(check all that apply)* ?

☐ Injury (complete part 3)

☐ Property Damage

☐ Motor Vehicle Collision (complete part 4) ?

☐ Near Miss

☐ Exposure (complete part 5)

What happened? (*attach additional sheets if required)* ?

What tools or equipment was being used at the time?

What type of event do you think this was? *(check all that apply)*

☐ fall on same level

☐ fall to lower level

☐ struck against stationary object

☐ caught in (pinch point)

☐ caught on (snagged/hung)

☐ struck by moving object

☐ overstress or overextension

☐ contact with energy (heat/cold, electricity, noise)

☐ near miss (no injury or damage)

☐ exposure to toxic/ infectious substance

☐ other *(describe):*

## PART 3 – Injury Report

Is "Injury" applicable to this report? *(check one)*

☐ YES *(Complete this section)* ☐ NO *(skip this section)*

How severe were the injuries? *(check all that apply)*

☐ Minor *(first aid treatment only required)*
☐ Serious *(medical examination at hospital / clinic required)*
☐ Time Lost *(person may miss time from their regular work)*

| Who are the injured person(s)? | |
|---|---|
| Name: | Sent to hospital? ☐ Yes ☐ No |
| Employee #: | Hospital (name): |
| Name: | Sent to hospital? ☐ Yes ☐ No |
| Employee #: | Hospital (name): |
| Name: | Sent to hospital? ☐ Yes ☐ No |
| Employee #: | Hospital (name): |
| Name: | Sent to hospital? ☐ Yes ☐ No |
| Employee #: | Hospital (name): |

What types of injuries were there? *(check all that apply)*

☐ wound/cut ☐ burn/scald ☐ sprain/strain
☐ fracture/dislocation ☐ loss of consciousness ☐ exposure to cold
☐ heat stroke/exhaustion ☐ eye injury ☐ loss of hearing
☐ loss of sight ☐ amputation ☐ heart attack/stroke
☐ other:(*describe*)

What body parts were affected? *(check all that apply)*

☐ Head ☐ Neck ☐ Back ☐ Torso ☐ Leg
☐ Ankle ☐ Foot ☐ Eye ☐ Wrist ☐ Shoulder
☐ finger ☐ Knee ☐ Hip ☐ Face
☐ other:(*describe*)

Additional Remarks *(if any)*:

# Halifax Regional Fire & Emergency
# Accident & Near Miss Report



## PART 4 – Motor Vehicle Collision Report

Is "Motor Vehicle Collision" applicable to this report? *(check one)*

☐ YES *(Complete this section)*　　☐ NO *(skip this section)*

| Name of HRFE Driver: | | Employee #: |
|---|---|---|
| Driver's License Master #: | Class: | Expiry: |
| Vehicle Unit #: | Vehicle Role *(i.e. "Engine 1")*: | |

What was the roadway like? *(check all that apply)*

| | | | | |
|---|---|---|---|---|
| ☐ Straight | ☐ Curved | ☐ On-grade | ☐ Level | ☐ Hillcrest |
| ☐ Wet | ☐ Mud/snow | ☐ Icy | ☐ Oily | ☐ Dry |
| ☐ 2 lane | ☐ 3 lane | ☐ 4 lane | ☐ Divided | ☐ One-way |
| ☐ Light controlled intersection | | ☐ Opticom | ☐ Rural | |
| ☐ Sign controlled intersection | | | | |
| ☐ other: *(describe)* | | | | |

What was the weather? *(check all that apply)*

| | | | | |
|---|---|---|---|---|
| ☐ Clear | ☐ Rain | ☐ Snow | ☐ Sleet | ☐ Dry |
| ☐ Other: (*describe*) | | | | |

Driver's statement: *(In this section, the driver shall describe the circumstances surrounding the accident)* ?

| Describe the other involved vehicles: | | ☐ N/A *(no other vehicle was involved)* | |
|---|---|---|---|
| 1) Make: | Model: | Color: | Plate #: |
| 2) Make: | Model: | Color: | Plate #: |

| Describe the other driver(s) information: | ☐ N/A *(no other driver was involved)* |
|---|---|
| Driver #1 Name: | Phone #: |
| Address: | |
| Driver's License Master #: | |
| Insurance Company: | Policy #: |
| Driver # 2 Name: | Phone #: |
| Address: | |
| Driver's License Master #: | |
| Insurance Company: | Policy #: |

| Describe witnesses: | ☐ N/A *(no witnesses)* |
|---|---|
| Name: | Phone #: |
| Address: | |
| Name: | Phone #: |
| Address: | |

| Describe attending police member: | ☐ N/A *(police did not attend)* |
|---|---|
| Name & Rank: | |
| Department: | |
| Additional Remarks *(if any)*: | |
| Signatures: | |
| Driver's Signature: | Date: |
| Supervisor's Signature: | Date: |

## PART 5 – Exposure Report

Is "Exposure" applicable to this report? *(check one)*

☐ YES *(Complete this section)* ☐ NO *(skip this section)*

| | |
|---|---|
| Name: | Sent to hospital? ☐ Yes ☐ No |
| Employee #: | Hospital (name): |
| Name: | Sent to hospital? ☐ Yes ☐ No |
| Employee #: | Hospital (name): |
| Name: | Sent to hospital? ☐ Yes ☐ No |
| Employee #: | Hospital (name): |
| Name: | Sent to hospital? ☐ Yes ☐ No |
| Employee #: | Hospital (name): |
| What time did this happen? | How long did the exposure last? |

What were people exposed to? *(check all that apply)*

☐ Blood ☐ Urine ☐ Saliva ☐ Vomitus ☐ Feces

☐ Respiratory droplets ☐ Other body contact *(describe)*:

☐ Chemical exposure *(describe):*

How were people exposed? *(check all that apply)*

☐ Inhalation ☐ Ingestion ☐ Puncture ☐ Skin contact ☐

☐ Other *(describe):*

What body parts were exposed? *(describe)* ?

Were any open cuts, sores, or rashes exposed? *(describe)* ?

What protective clothing was in use at the time? *(check all that apply)*

☐ Exam gloves ☐ Safety glasses ☐ N95 respirator ☐ Disposable gown

☐ SCBA ☐ Other *(describe):*

What cleaning & disinfection methods did you use? *(describe)*

| | |
|---|---|
| Member's Signature *(if available)*: | Date: |
| Member's Signature *(if available)*: | Date: |
| Member's Signature *(if available)*: | Date: |
| Member's Signature *(if available)*: | Date: |
| Supervisors' Signature: | Date: |