GALACTICO COACHING

Accident Report Forms

Contents

Contents ……. 2
Accident Forms ……..... 3
1. Employee Accident form - First Report …… 3
2. Employee Incident/Accident Report ..…… 5
3. Supervisor Accident Report Form ..…… 10
4. Return to Work Form - Supervisor ……..…….. 15
5. Employee Return to Work Plan ……..…… 16
6. Witness to Accident Statement …….. 18
7. Near-Miss Report Form …… 19
8. Workplace Violence Incident Report …….. 20
9. General Staff Incident Report …….. 22
10. Health and Safety Incident Report Form …… 24
11. Participant Accident Report Form …… 26
12. Coach Participant Accident Report Form …… 30

Employee Accident form - First Report

Employees shall report all work related accidents, injuries and illnesses using this form. Once completed, this form should be given to the Director.

What are you reporting?	☐ Accident ☐ Injury ☐ Illness ☐ Near-miss
Name:	
Date of report:	
Job Title:	
Location of Incident:	
Date and Time of Incident:	
Witnesses (if any):	
Incident description:	
What could have been done to prevent this?	
What parts of your body were injured/ill? **If it was a near miss, how could you have been hurt?**	
Was medical treatment necessary?	☐ Yes ☐ No **If yes, please give further detail specifying the name of the doctors/hospital, the date and time of your visit, and contact details for them:**
Has this part of your body been injured before?	☐ Yes ☐ No **If yes, please provide details of when:**
Do you have other employment?	☐ Yes ☐ No **If yes, please provide the name of the company:**

Employee Signature: **Date:**	
Director Signature: **Date:**	

Employee Incident/Accident Report

Employee Information

Name:	
Date of Birth:	
Job Title:	
Address:	
Email Address:	
Phone Number:	

Incident Description

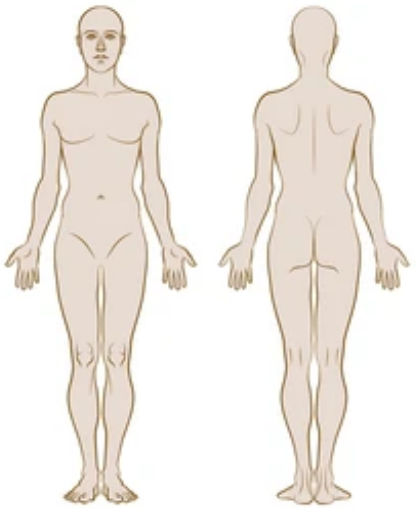
Location:	
Date and Time of Incident:	
Incident Description: ***(what caused the incident/accident/injury, what you were doing just before the incident, what you did after the incident).***	
Were you performing regular duties at the time of the incident?	☐ Yes ☐ No
Did anyone see you get hurt?	☐ Yes ☐ No **If yes, please list all witnesses:**
Did you report the incident to anyone?	☐ Yes ☐ No
If you reported the incident to someone, please give details:	**Name:** **Job Title:** **Date Reported:**
If you did not report the incident to someone, please explain why you chose not to report:	
Did the injury cause loss of time from work? *(Dates, amount of time).*	

Injury Description

Nature of Injury *(please select all that apply)*

☐	Abrasion, Scrapes	☐	Amputation	☐	Broken Bone	☐	Bruise
☐	Burn (heat)	☐	Burn (chemical)	☐	Concussion	☐	Crushing Injury
☐	Cut, Laceration, Punction	☐	Dislocation	☐	Hernia	☐	Illness
☐	Knee Injury	☐	Sprain, Strain	☐	Damage to Body System	☐	OTHER

If OTHER, please describe:	

Description of Injury:	**Part of the body affected: *(please shade all that apply)*** 

Was first aid administered at the scene?	☐ Yes ☐ No **If yes, please describe the first aid administered and who administered it:**

Was medical treatment necessary?	☐ Yes ☐ No
If medical treatment was necessary, please provide details:	**Name of Hospital/Doctors:** **Date and Time of Visit:** **Hospital/Doctors Phone Number:** **Treatment Received:**
Were you treated in an emergency room?	☐ Yes ☐ No
Were you taken by ambulance?	☐ Yes ☐ No
Have you ever had a similar injury?	☐ Yes ☐ No **If yes, please describe the previous injury:**
Has a similar injury been treated?	☐ Yes ☐ No **If yes, please provide details on where, when, and by whom were you treated:**

Back Injury Report:

To be completed when a back injury is reported by the injured employee. *(If not applicable, skip to the "Previous Compensation Claims" section).*

What part of your back hurts now?	
When did you first notice this back pain?	**Date:** **Time:**
What were you doing at that time? Explain in detail.	

If you were lifting a heavy object, what was it and how heavy was it?	
What did you feel?	
What was the length of time between the injury and your disability, if any?	
Did anyone see you get hurt?	☐ Yes ☐ No **If yes, please list all witnesses:**
Did you report this incident to anyone?	☐ Yes ☐ No
If you reported the incident to someone, please give details:	**Name:** **Job Title:** **Date Reported:**
Did you ever have a back injury before?	☐ Yes ☐ No **If yes, please provide details of when and what part of your back:**
Were you ever treated by a doctor?	☐ Yes ☐ No **If yes, please provide details on where, when, and by whom were you treated:**
If previously injured, has it given you trouble since? Explain.	

Previous Compensation Claims

Have you ever received or filed for compensation because of a back injury?	☐ Yes ☐ No
Have you ever received or filed for compensation due to any other injury?	☐ Yes ☐ No
If yes, please list the compensation claim numbers:	

Medical Release

I hereby authorise any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury / illness described above, to disclose such information to my employer, and any third party that my employer finds necessary. A copy of this form will serve as the original.

Employee Name (PRINT):	
Employee Signature:	
Date:	

Report Submitted by:

Name:	
Signature:	
Date:	

Report Received by:

Name:	
Signature:	
Date:	

Supervisor Accident Report Form

This form serves to document *(select all that apply)*

☐	Near Miss	☐	First Aid Only	☐	ER/Clinic Treatment
☐	Lost Time	☐	Death	☐	Other: *(Specify)*

Report completed by

Name:	
Job Title:	
Date of Incident:	
Date of Report:	

Injured Employee Information

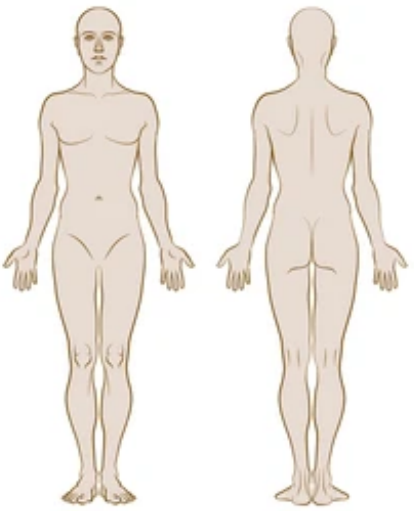
Name:	
Date of Birth:	
Job Title *(at the time of incident)*:	
Date of Hire:	
Rate of Pay:	
Employee Status:	☐ Full-Time ☐ Part-Time ☐ Other : _____
Hours Per Day:	
Days Per Week:	

Nature of Injury *(please select all that apply)*

☐	Abrasion, Scrapes	☐	Amputation	☐	Broken Bone	☐	Bruise
☐	Burn (heat)	☐	Burn (chemical)	☐	Concussion	☐	Crushing Injury
☐	Cut, Laceration, Punction	☐	Dislocation	☐	Hernia	☐	Illness

☐	Knee Injury	☐	Sprain, Strain	☐	Damage to Body System	☐	OTHER

If OTHER, please describe:	

Description of Injury:	**Part of the body affected:** ***(please shade all that apply)*** 

Location of Incident:	
Date and Time of Incident:	
What part of the employees workday did the incident occur?	☐ Entering/Leaving Work ☐ Doing Normal Work Activities ☐ During Meal Period ☐ During Break ☐ Working Overtime ☐ OTHER : _____
Were there any witnesses?	☐ Yes ☐ No **If yes, please provide a list of names:**
Please list any personal protective equipment used at the time of the incident:	

Incident Description: ***(what caused the incident/accident/injury, what you were doing just before the incident, what you did after the incident).***	
Attachments: ***(list anything that needs to be submitted with this report - forms, witness statements, photographs, maps, drawings etc).***	

Why did the incident occur?

Unsafe Workplace conditions: ***(Select all that apply)***	☐ Inadequate guard ☐ Unguarded hazard ☐ Safety device is defective ☐ Tool/equipment is defective ☐ Layout is hazardous ☐ Unsafe lighting ☐ Unsafe ventilation ☐ Lack of needed personal protective equipment ☐ Lack of appropriate equipment/tools ☐ Unsafe clothing ☐ No training/insufficient training ☐ OTHER: _____
Unsafe Acts by People: ***(Select all that apply)***	☐ Operating without permission ☐ Operating at unsafe speed ☐ Servicing equipment that has power to it ☐ Making a safety device inoperative ☐ Using defective equipment ☐ Using equipment in an unapproved way ☐ Unsafe lifting ☐ Taking an unsafe position/posture ☐ Distraction, teasing, horseplay ☐ Failure to wear personal protective equipment ☐ Failure to use the available equipment/tools ☐ OTHER: _____
Why did the unsafe conditions exist?	

Why did the unsafe acts occur?	
Is there a workplace culture, norm, or expectation that may have encouraged the unsafe conditions or acts?	☐ Yes ☐ No **If yes, please describe:**
Were the unsafe acts or conditions reported prior to the incident?	☐ Yes ☐ No
Have there been similar incidents or near misses prior to this one?	☐ Yes ☐ No

How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again? ***(Select all that apply)***	☐ Stop this activity ☐ Train the employees ☐ Redesign task steps ☐ Write a new policy/rule ☐ Routinely inspect for the hazard ☐ Guard the hazard ☐ Train the supervisors ☐ Redesign layout ☐ Enforce existing policy ☐ Personal protective equipment ☐ OTHER: _____
What should be (or has been) done to carry out the suggestions selected above?	

Report Written by:

Name:	
Job Title:	
Date:	

Report Reviewed by:

Name:	
Job Title:	
Date:	

Report Submitted by:

Name:	
Signature:	
Date:	

Report Received by:

Name:	
Signature:	
Date:	

Return to Work Form - Supervisor

Report Completed by:

Name:	
Job Title:	

Details of the Employee Returning to Work:

Name:	
Date of Return:	
The Employee is:	☐ Performing their full duties with no restrictions. ☐ Performing their duties with restrictions. ☐ Returning to work on a transitional work effort; and/or alternative duty has been assigned with restrictions. ☐ Working their full schedule. ☐ Working a partial day: ____*hrs. Start Time:* _____ *End Time:* _____

Comments:	

Acknowledgement

Injured Worker	**Name:**	**Signature:**	**Date:**
Supervisor	**Name:**	**Signature:**	**Date:**

Employee Return to Work Plan

Name of Injured Worker:	
Job Title:	
Supervisor's Name:	

Date and Time of Return:	
Restrictions from Doctors:	
Review and Briefing which has occurred:	☐ The Doctor's restrictions have been identified and clarified. ☐ The Supervisor is able to understand the restrictions and provide accommodated work. ☐ A communication pathway to get support has been provided to the injured worker. ☐ A review of pertinent safety policies/practices has occured. ☐ A review of the injured workers duties has been carried out, and duties have been assigned as noted below. ☐ Requirements of the injured worker to work within restrictions have been clarified. ☐ Requirements of the supervisor to only assign work within restrictions have been clarified. ☐ Requirement of the injured worker to immediately go to their Doctors (or emergency room) if they are leaving work because theyfeel thatthey cannot perform the work or because they feel they may have been re-injured. ☐ _____ ☐ _____

AGREEMENT: I, the undersigned injured worker, agree to participate in the transitional work plan described below. I agree to consider work to be performed carefully and to work within my restrictions, ask for help when work exceeds my abilities, and to notify my supervisor if there are duties assigned that exceed by abilities, or if I need assistance.

Injured Worker	**Name:**	**Signature:**	**Date:**
Supervisor	**Name:**	**Signature:**	**Date:**

Assigned Tasks:

Week No	Assigned Duties	Employee Feedback	Supervisor Feedback	Continue Modified Duty? YES/NO	Full Return to Work? YES/NO
1					
2					
3					
4					
5					
6					
7					
8					

Witness to Accident Statement

Injured Employee Information

Name of Injured Employee:	
Job Title:	
Shift incident occured on:	

Witness Statement

Your name was provided as a witness by the employee listed above. In order to complete a timely and thorough investigation of this incident, please provide the following details and submit your completed statement to the Director as soon as possible.

Witness Name:	
Job Title:	
Address:	
Phone Number:	
Email:	
Did you see an incident involving the above mentioned employee?	☐ Yes ☐ No
If you did not see the accident, how did you learn about it?	
If you did see the accident, please provide details:	**Location:** **Date and Time:** **Description:**

Acknowledgement

Witness	**Name:**	**Signature:**	**Date:**
Report Received by	**Name:**	**Signature:**	**Date:**

Near-Miss Report Form

This form is used to report hazards or conditions that have the potential to cause an accident, injury, or illness in the workplace.

Your Details

Name *(Optional):*	
Job Title *(Optional):*	
Phone Number *(Optional):*	
Email *(optional):*	
Date Reported:	

Incident details

Date and Time of Incident:	
Location:	
Conditions *(Select all that apply):*	☐ Near-miss ☐ Safety concern ☐ Safety Suggestion ☐ OTHER: _____
Type of Concern *(Select all that apply):*	☐ Unsafe Act ☐ Unsafe Condition of Area ☐ Unsafe Condition of Equipment ☐ Unsafe Use of Equipment ☐ OTHER: _____
Incident Description: ***(Please give as much detail as possible, describe the potential incident/hazard/concern and the possible outcome).***	
Safety Suggestions: ***(Describe corrective measures that we could take to address immediate hazards related to the incident).***	

Workplace Violence Incident Report

Reported by:	
Job Title:	
Phone Number:	
Email:	
Date of Report:	

Workplace Violence Incident Information

Name of Person Demonstrating Prohibited Behaviour:	
Name of Victim:	
Location:	
Date and Time of Incident:	
Additional Person(s) involved:	
Witnesses:	
Incident Description: ***(Include any events leading to or immediately following the incident).***	
Names of Supervisory Staff Involved: ***(Include their responses to the incident).***	
Resulting Action Executed, Planned, or Recommended:	

Was there a police report filed?

Police Report Filed?	☐ Yes ☐ No
Precinct:	
Reporting Officer:	
Phone Number:	
Police Action Taken:	

Acknowledgement

Witness	**Name:**	**Signature:**	**Date:**
Report Received by	**Name:**	**Signature:**	**Date:**

General Staff Incident Report Form

Employee Name:	
Job Title:	
Manager Name:	
Job Title:	
Date:	

Incident Details

Location:	
Date and Time:	
Description of Incident:	
Employee Explanation:	
Witnesses:	
Action to be Taken:	☐ Verbal Warning ☐ Written Warning ☐ Probation ☐ Suspension ☐ Dismissal ☐ OTHER: _____
Explanation of Action to be Taken:	

Acknowledgement

By signing this form, you acknowledge that you have read and understood the information contained herein.

Employee Name *(PRINT):*	
Employee Signature:	
Date:	

Employer Name *(PRINT):*	
Employer Signature:	
Date:	

Health and Safety Incident Report Form

This form needs to be filled out immediately after a work-related incident and submitted to the Director.

Name:	
Job Title:	
Phone Number:	
Email:	
Date:	

Incident Details

Location of Incident:	
Date and Time:	
Incident Type:	☐ Accident ☐ Violence ☐ Incident ☐ Ill Health ☐ Near-Miss ☐ Safety ☐ OTHER: _____
Incident Description: ***(Report any details that may have contributed to the incident).***	
Outcome Description: ***(Detail all harm/health effects/damage).***	
Corrective Measures: ***(Describe the corrective measures taken to address immediate hazards related to the incident).***	

Individual Affected

Name:	
Date of Birth:	

Job Title:	
Phone Number:	
Email:	
Home Address:	

Witness Details

Name	**Contact Information**

First Aid

Was First Aid Administered?	☐ Yes ☐ No
If First Aid was Administered, Please Provide Details:	Administered by: Contact Information: Time of Administration:
Details of First Aid Administered:	

Post Incident

Where did the Individual Affected Go Next?	☐ To the Hospital ☐ Home ☐ Returned to Work ☐ OTHER:_____
Was the Director kept informed about the incident?	☐ Yes ☐ No

Additional Details

Participant Accident form

Participants should report all Galactico Coaching Activity-related accidents, injuries and illnesses using this form with help from a member of staff. Once completed, this form should be given to the Director. Parents will be consulted to ensure accurate answers.

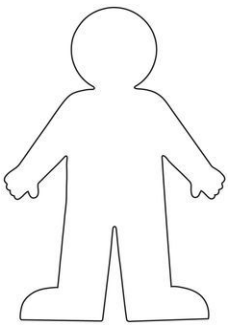
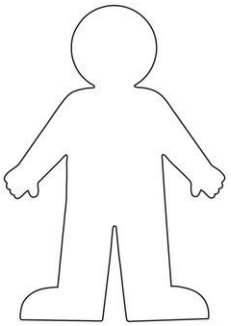
What are you reporting?	☐ Accident ☐ Injury ☐ Illness ☐ Near-miss
Name:	
Date of Birth:	
Participant/Parent Contact Details:	
Date of report:	
Activity/Session/Camp:	
Location of Incident:	
Date and Time of Incident:	
Witnesses (if any):	
Incident description: ***(what caused the incident/accident/injury, what you were doing just before the incident, what you did after the incident).***	
Were you engaging in an activity which was planned by the coach?	☐ Yes ☐ No **If yes, please give details of the activity:**
Were you following the instructions and being sensible during this activity?	☐ Yes ☐ No **Please give details of what you were doing to follow or not to follow the instructions:**

What could have been done to prevent this?	

Nature of Injury ***(please select all that apply)***

☐	Abrasion, Scrapes	☐	Amputation	☐	Broken Bone	☐	Bruise
☐	Burn (heat)	☐	Burn (chemical)	☐	Concussion	☐	Crushing Injury
☐	Cut, Laceration, Punction	☐	Dislocation	☐	Hernia	☐	Illness
☐	Knee Injury	☐	Sprain, Strain	☐	Damage to Body System	☐	OTHER

If OTHER, please describe:	

Description of Injury: ***(If it was a near miss, how could you have been hurt?)***	**Part of the body affected:** ***(please shade all that apply)*** ***FRONT***  ***BACK*** 

Reporting and Treatment

Did you report the incident to anyone?	☐ Yes ☐ No
If you reported the incident to someone, please give details:	**Name:** **Job Title:** **Date Reported:**
If you did not report the incident to someone, please explain why you chose not to report:	
Was first aid administered at the scene?	☐ Yes ☐ No **If yes, please describe the first aid administered and who administered it:**
Was medical treatment necessary?	☐ Yes ☐ No
If medical treatment was necessary, please provide details:	**Name of Hospital/Doctors:** **Date and Time of Visit:** **Hospital/Doctors Phone Number:** **Treatment Received:**
Were you treated in an emergency room?	☐ Yes ☐ No
Were you taken by ambulance?	☐ Yes ☐ No
Did the injury cause you not to be able to participate in physical activity? ***(Dates, amount of time).***	
Has this part of your body been injured before?	☐ Yes ☐ No **If yes, please provide details of when and the treatment received:**

Have you ever had a similar injury?	☐ Yes ☐ No **If yes, please describe the previous injury:**
Has a similar injury been treated?	☐ Yes ☐ No **If yes, please provide details on where, when, and by whom were you treated:**

Report Submitted by:

Name:	
Signature:	
Date:	

Report Received by:

Name:	
Signature:	
Date:	

Coach Participant Accident Report Form

This form serves to document *(select all that apply)*

☐	Near Miss	☐	First Aid Only	☐	ER/Clinic Treatment
☐	Lost Time	☐	Death	☐	Other: *(Specify)*

Report completed by

Name:	
Job Title:	
Date of Incident:	
Date of Report:	

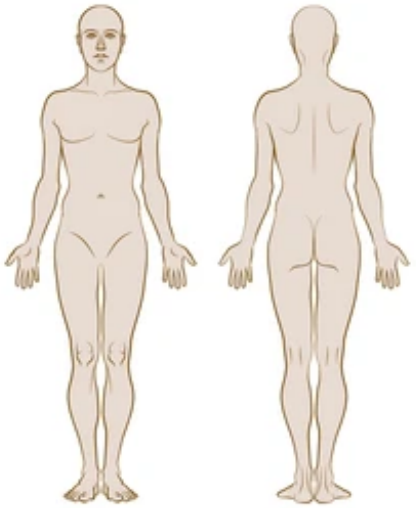
Injured Participant Information

Name:	
Date of Birth:	
Activity/Session/Camp:	
Dates and Times Attended:	
Participant/Parents Contact Details:	

Nature of Injury *(please select all that apply)*

☐	Abrasion, Scrapes	☐	Amputation	☐	Broken Bone	☐	Bruise
☐	Burn (heat)	☐	Burn (chemical)	☐	Concussion	☐	Crushing Injury
☐	Cut, Laceration, Punction	☐	Dislocation	☐	Hernia	☐	Illness
☐	Knee Injury	☐	Sprain, Strain	☐	Damage to Body System	☐	OTHER

If OTHER, please describe:	

Description of Injury:	Part of the body affected: *(please shade all that apply)* 

Location of Incident:	
Date and Time of Incident:	
What activity did it occur during?	
Were there any witnesses?	☐ Yes ☐ No **If yes, please provide a list of names:**
Please list any personal protective equipment used at the time of the incident:	
Incident Description: ***(what caused the incident/accident/injury, what you were doing just before the incident, what you did after the incident).***	
Attachments: ***(list anything that needs to be submitted with this report - forms, witness statements, photographs, maps, drawings etc).***	

Why did the incident occur?

Unsafe conditions: ***(Select all that apply)***	☐ Inadequate guard ☐ Unguarded hazard ☐ Safety device is defective ☐ Tool/equipment is defective ☐ Layout is hazardous ☐ Unsafe lighting ☐ Unsafe ventilation ☐ Lack of needed personal protective equipment ☐ Lack of appropriate equipment/tools ☐ Unsafe clothing ☐ OTHER: _____
Unsafe Acts by People: ***(Select all that apply)***	☐ Operating without permission ☐ Operating at unsafe speed ☐ Not listening to instruction ☐ Making a safety device inoperative ☐ Using defective equipment ☐ Using equipment in an unapproved way ☐ Unsafe lifting ☐ Taking an unsafe position/posture ☐ Distraction, teasing, horseplay ☐ Failure to wear personal protective equipment ☐ Failure to use the available equipment/tools ☐ OTHER: _____
Why did the unsafe conditions exist?	
Why did the unsafe acts occur?	
Were the unsafe acts or conditions reported prior to the incident?	☐ Yes ☐ No If yes, please explain:
Have there been similar incidents or near misses prior to this one?	☐ Yes ☐ No If yes, please explain:

How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again? ***(Select all that apply)***	☐ Stop this activity ☐ Redesign task steps ☐ Write a new policy/rule ☐ Routinely inspect for the hazard ☐ Guard the hazard ☐ Redesign layout ☐ Enforce existing policy ☐ Personal protective equipment ☐ OTHER: _____
What should be (or has been) done to carry out the suggestions selected above?	

Report Written by:

Name:	
Job Title:	
Date:	

Report Reviewed by:

Name:	
Job Title:	
Date:	

Report Submitted by:

Name:	
Signature:	
Date:	

Report Received by:

Name:	
Signature:	
Date:	