University of Manitoba

Notice of Incident / Near Miss

Form to be completed for all incidents, injuries, and near misses. A Worker's Compensation Worker Report needs to be completed for incidents requiring medical assistance or time loss. To submit a Worker Report employees and students may call WCB at (204) 954-4321 or submit online at https://www.securewcb.mb.ca/iwfr/Welcome
Forms are located on the UM Occupational Health web page at:
http://umanitoba.ca/admin/vp_admin/risk_management/ehso/occ_health_comp/aiwcb.html

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.

Name of individual involved: **Date of incident:**

Department: **Supervisor Phone #:**

Location: **Time:** **a.m.__ p.m.**

Cause of incident

What were you doing at the time of the incident?

What was injured? (Please note left or right, if applicable).

Did you report the incident immediately? **To whom?**
If not what was your reason?

Have you seen or do you plan to see a healthcare provider?
(If you miss work due to an incident, you must see a healthcare provider on the first day you miss work and provide medical updates until you return to work.)

Name and Address of Healthcare Provider:

Witness Name: **Phone #:**

Name of Supervisor: **Phone #:**

Signature of Supervisor: **Date:**

Signature of Individual: **Date:**

Distribution:
Supervisor – original
Cc to Employee – copy
Cc to EHS – Email copy to: OHReport@umanitoba.ca

Updated February 2022