



# INJURY REPORT

CF-S-09A

iTrak #:

**\*CF-S-09 is required to be completed along with this form\***

**\*Complete one form for each injured person!\***

### INJURED/ ILL PERSON INFORMATION

Name of injured person: \_\_\_\_\_

Shift Day: \_\_\_\_\_ of \_\_\_\_\_ days      Shift Hour: \_\_\_\_\_ of \_\_\_\_\_ hours

Industry Experience: \_\_\_\_\_ years      Company Experience: \_\_\_\_\_ years

### TASK BEING PERFORMED AT TIME OF INCIDENT:

- |                                            |                                                |                                               |                                            |                                           |
|--------------------------------------------|------------------------------------------------|-----------------------------------------------|--------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Boring            | <input type="checkbox"/> Driving               | <input type="checkbox"/> Fueling              | <input type="checkbox"/> Maintenance       | <input type="checkbox"/> Pressure Testing |
| <input type="checkbox"/> Clearing/ Logging | <input type="checkbox"/> Electrical            | <input type="checkbox"/> Hoisting             | <input type="checkbox"/> Material Handling | <input type="checkbox"/> Office Work      |
| <input type="checkbox"/> Cutting/ Grinding | <input type="checkbox"/> Excavation            | <input type="checkbox"/> Job Site Preparation | <input type="checkbox"/> Pile Driving      | <input type="checkbox"/> Walking          |
| <input type="checkbox"/> Demolition        | <input type="checkbox"/> Fabrication           | <input type="checkbox"/> Lifting              | <input type="checkbox"/> Pipe Handling     | <input type="checkbox"/> Welding          |
| <input type="checkbox"/> Drilling          | <input type="checkbox"/> Fabrication - Modular |                                               |                                            |                                           |

### OCCUPATION:

- |                                             |                                                |                                       |                                          |                                                  |
|---------------------------------------------|------------------------------------------------|---------------------------------------|------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Crane Operator     | <input type="checkbox"/> Iron Worker           | <input type="checkbox"/> Mechanic     | <input type="checkbox"/> Welder          | <input type="checkbox"/> Support Staff           |
| <input type="checkbox"/> Electrician        | <input type="checkbox"/> Instrument Technician | <input type="checkbox"/> Pipefitter   | <input type="checkbox"/> Welder's Helper | <input type="checkbox"/> Senior Management       |
| <input type="checkbox"/> Equipment Operator | <input type="checkbox"/> Labourer              | <input type="checkbox"/> Truck Driver | <input type="checkbox"/> Line Management | <input type="checkbox"/> Superintendent/ Foreman |
- If Trade, is the worker an apprentice?     Yes     No    If yes, what year?     1st     2nd     3rd     4th

### ENVIRONMENTAL CONDITIONS:

- Light Conditions:     Artificial     Bright Sun     Daylight     Night
- Bright Lights     Dawn     Dusk     Overcast
- Weather Conditions:     Blizzard     Freezing Rain     Light Snow     Dust
- Chinook     Hail     Overcast     Sandstorm
- Clear     Heavy Rain     Sleet     Sunny
- Cloudy     Heavy Snow     Smoke     Windy
- Fog/ Mist     Light Rain
- Wind Direction:     North     North West     South East     South West
- North East     East     South     West
- Wind Speed: (estimated km/hr) \_\_\_\_\_ km/hr    Precipitation (amount at time of incident): \_\_\_\_\_ cm/mm (circle one)    Temperature (estimated °C) \_\_\_\_\_ °C

### INJURY/ ILLNESS INCIDENT FACTS AND DETAILS:

**From the lists below, select the part of the body injured, nature of injury and the location of the injury. If multiple body parts are injured, continue filling in the table with one body part per box**


- Part of Body Injured:     Arm-Lower     Ears     Groin     Mouth/ Teeth
- Arm - Upper     Elbow     Hand/ Wrist     Neck
- Abdomen     Eyes     Head     Scalp
- Toes     Face     Hips     Skull
- Back     Feet/ Ankle     Knee     Shoulder
- Chest Ribs     Finger/ Thumb     Legs     Thigh
- Nature of Injury:     Abrasion     Crush     Fracture     Poisoning     Strain
- Bruise     Cut     Foreign Body     Puncture     Toxic Substance
- Break     Dermatitis     Hernia     Sprain     Unconscious
- Burn     Exposure to gas/ chemical     Noise     Sting/ Bite

- Location of Injury:     Front     Back     Right     Left
- Immediate Cause of Injury     Absorption     Extreme Heat     Line of Fire     Slip/ Fall - Different Level
- Electrical Shock     Inhalation     Pinch Points/ Crush Points     Strain/ Overexertion
- Exposure to Gas     Ingestion     Sharp Surfaces/ Edges     Struck By
- Extreme Cold     Lifting/ Pulling     Slip/ Fall - Same Level

### Follow Up:

- Was a WCB Report Submitted?     Yes     No    If yes, What was the WCB Claim Number? \_\_\_\_\_
- Minutes to Medical Facility: \_\_\_\_\_ min    Kilometers to Medical Facility: \_\_\_\_\_ km    Name of Medical Facility: \_\_\_\_\_
- Method of Transportation to Medical Facility:     Air     Ambulance     Medical Transport Vehicle     Regular Vehicle
- Medical Care Provided By:     First Aider     On-site Medic     Walk-In Clinic     Emergency     Hospital