

JOINT ACCIDENT INVESTIGATION FORM

PSC 38

Ministry		Tel.#		Location		Date of Report	
Last Name of Injured (or ill) Person				First Name		File No:	
Years of Service		Time on Present Job		Occupation		Hours worked in Previous 24 hour period	
Accident Location (Dept. or Area)				Date of Accident		Time	
Accident Category (check)	<input type="checkbox"/> injury or illness	<input type="checkbox"/> Equipment Malfunction	<input type="checkbox"/> Motor Vehicle	<input type="checkbox"/> Property Damage	<input type="checkbox"/> Fire	<input type="checkbox"/> other (specify)	
Severity of Injury or Illness(check)		<input type="checkbox"/> No Injury or First Aid Only		<input type="checkbox"/> Medical Treatment	<input type="checkbox"/> Time Loss	<input type="checkbox"/> Fatal*	
Nature of Injury or Illness							
Description of Accident or Employee's Account of Occupational Disease (e.g. RSI) (use separate sheet if necessary)							
Were Written Safe Work Procedures Established and Available?			Were they Adequate?			Were these Safe Work Procedures used in Training?	
Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Basic Cause (and Contributory Factors) EXPLAIN FULLY UNSAFE CONDITIONS							

Corrective Measures Taken and/or Recommended

Corrective Action Referred to _____ Date to be Completed by ____/____/____

Additional Comments or Observations. Where applicable give details of makes and models of machines, equipment, tools, structures, etc., involved in this accident. (Use separate sheet if necessary)

Name(s) and occupations of person(s) who investigated accident:

_____	_____	_____	_____
Print Name & Occupation	Phone	Print Name and Occupation	Phone
_____	_____	_____	_____
Signature of Workers' Representative	Date	Signature of Employer Representative	Date

Name(s) of Witness(s) (include phone number)

Revised July 2004

* If fatal, ensure you contact the local WCB office as per #172, part 3 of the WC Act, BCGEU President, Local BCGEU office and the Deputy Minister, BC Public Service Agency

IF this is an infectious disease exposure, please fax a copy to Occupational Health Programs, BC Public Service Agency at 604-775-0697.

Keep Original and Forward Copy to: (1) Ministry Designate; (2) BCGEU Area Office; (3) Local JHS Committee & (4) Local WCB Office