Occupational Health & Safety and Staff Abuse

REPORT FORM

Immediately file this form with your Local Union. Keep a copy for your records.

Local File #: _____

Local #: _____ Employer: _____

Worksite (ward/unit/office): _____ Date & Time/Shift: _____

Describe the Nature of Incident ***(Do not use names of patients, clients, residents, staff or doctors)***:

_____

What is the suspected hazard?: _____

Any injury or disease related to problem? (if known):

_____

What action is required?:

_____

Was the incident reported to your Supervisor?: yes ☐ no ☐

Name of Supervisor: _____ Date of Discussion: _____

Action Taken:

_____

_____ _____ _____

Name (Printed) E-Mail Phone No.

_____ _____

Signature Date

United Nurses of Alberta

900-10611 98 Avenue Edmonton AB T5K 2P7 • 425-1025 (ph) • 426-2093 (fx)

This form does not replace a Workers' Compensation Form, Occupational Hazard Form or Employer Incident Form. Please file these forms where appropriate.

A Workers' Compensation Form must be filed if any injury has resulted or if there is any possibility of disease or injury which may result from the hazard.

OH&S Form • May 2009 • Kld • CEP

1st Copy - Union/OH&S Committee • Second Copy - Employee