



Employer Incident Investigation Report (EIIR)

Please refer to the companion [quick guide](#) for assistance completing the investigation and this form.

1. Employer's information

| | | |
|---|---------------------------|----------------------------------|
| Employer's name (legal name and trade name) | | |
| WorkSafeBC account number | Operating location number | |
| Employer's head office address | | |
| City | Province | Postal code |
| Employer's representative's name | | Phone number (include area code) |
| Email address | | |

2. Injured persons

| Last name | First name | Job title |
|-----------|------------|-----------|
| a) | | |
| b) | | |
| c) | | |
| d) | | |

3. Place, date, and time of incident

| | | |
|--|--|-------------|
| Location where incident occurred (street address or GPS coordinates) | | |
| City (nearest) | Province | Postal code |
| Date of incident (yyyy-mm-dd) | Time of incident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |

4. Type of occurrence (select all that apply)

| | |
|--|---|
| <input type="checkbox"/> Death of a worker | <input type="checkbox"/> Dangerous incident involving explosives other than blasting incident |
| <input type="checkbox"/> Serious injury to a worker | <input type="checkbox"/> Diving incident, as defined by regulation |
| <input type="checkbox"/> Major structural failure or collapse | <input type="checkbox"/> Incident of fire or explosion with potential for serious injury |
| <input type="checkbox"/> Major release of hazardous substance | <input type="checkbox"/> Minor injury or no injury but had potential for causing serious injury |
| <input type="checkbox"/> Blasting accident causing personal injury | <input type="checkbox"/> Injury requiring medical treatment beyond first aid |

An incident investigation report is NOT required under the *Workers Compensation Act* if none of the above applies or if this incident is a vehicle accident occurring on a public street or highway.

5. Report type (select all that apply)

If this is a revised version of a previous report, please check here

| | | | |
|--|---|---|--|
| <input type="checkbox"/> Preliminary Investigation Report Report date (yyyy-mm-dd) Only provide to a WorkSafeBC officer if requested Officer's name | <input type="checkbox"/> Interim Corrective Action Report Report date (yyyy-mm-dd) | <input type="checkbox"/> Full Investigation Report Report date (yyyy-mm-dd) Must be provided to WorkSafeBC within 30 days* Fax 1.866.240.1434 Date sent (yyyy-mm-dd) | <input type="checkbox"/> Full Corrective Action Report Report date (yyyy-mm-dd) |
|--|---|---|--|

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6. Witnesses

| Last name | First name | Job title |
|-----------|------------|-----------|
| a) | | |
| b) | | |
| c) | | |

7. Other persons whose presence might be necessary for proper investigation

| Last name | First name | Job title |
|-----------|------------|-----------|
| a) | | |
| b) | | |

8. Sequence of events that preceded the incident

Required in Preliminary Report. Update in Full Report if necessary. Describe events earlier that day or even in previous years that led up to the incident. Examples may include events such as training given or changes in equipment, procedures, or company management.

9. Unsafe conditions, acts, or procedures that significantly contributed to the incident

Required in all reports. Describe anything, or the absence of anything, that contributed to the hazard such as poor housekeeping or poor visibility, using equipment without guards, or the lack of safe work procedures.

10. Nature of the serious injury (optional – complete only if there has been an injury)

- | | |
|---|---|
| <input type="checkbox"/> Life threatening or resulting in loss of consciousness | <input type="checkbox"/> Punctured lung or other serious respiratory condition |
| <input type="checkbox"/> Major broken bones in head, spine, pelvis, arms, or legs | <input type="checkbox"/> Injury to internal organ or internal bleeding |
| <input type="checkbox"/> Major crush injuries | <input type="checkbox"/> Injury likely to result in loss of sight, hearing, or touch |
| <input type="checkbox"/> Major cut with severe bleeding | <input type="checkbox"/> Injury requiring CPR or other critical intervention |
| <input type="checkbox"/> Amputation of arm, leg, or large part of hand or foot | <input type="checkbox"/> Diving illness such as decompression sickness or near drowning |
| <input type="checkbox"/> Major penetrating injuries to eye, head, or body | <input type="checkbox"/> Serious chemical or heat/cold stress exposure |
| <input type="checkbox"/> Severe (third-degree) burns | <input type="checkbox"/> Other (specify) |

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11. Brief description of the incident

Required in Preliminary Report. Briefly, summarize the sequence of events, the unsafe factors, and the resulting injury, if any.

12. Corrective actions identified and taken to prevent recurrence of similar incidents

| Action (Required in Preliminary Report and Interim Corrective Action Report. Update in Full Report, if necessary.) | Action assigned to (name and job title) | Expected completion date (yyyy-mm-dd) | Completed date (yyyy-mm-dd) |
|---|--|--|--------------------------------|
| a) | | | |
| b) | | | |
| c) | | | |
| d) | | | |
| e) | | | |

13. Explanation of blank areas on this Preliminary Report, if any

If there are blank areas, describe the circumstances beyond your control that explain this lack of information.

14. Persons who carried out or participated in the preliminary investigation

| Representative | Name | Job title | Signature (optional) | Date signed (yyyy-mm-dd) |
|---------------------------------------|------|-----------|----------------------|-----------------------------|
| Employer representative (required) | | | | |
| Worker representative (required) | | | | |
| Other | | | | |
| Other | | | | |

End of report

Completing all the sections above satisfies the requirements for a Preliminary Investigation Report and an Interim Corrective Action Report.

Note: If this was a simple investigation and **all needed corrective actions have been completed within 48 hours**, the Preliminary and Full Investigation portions of the report can be completed at the same time. If so, you can check both the Preliminary Investigation Report and the Full Investigation Report boxes in section 5 on page 1.

As of January 1, 2016, copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.

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15. Determination of causes of incident

Required in Full Report. Analyze the facts and circumstances of the incident to identify underlying factors that led to the incident. Underlying factors include factors that made the unsafe conditions, acts, or procedures in the Preliminary Report possible. Update items from section 9, if needed.

16. Full description of the incident

Required in Full Report. Use the brief description from the Preliminary Report and update it, if necessary.

17. Additional corrective actions necessary to prevent recurrence of similar incidents

| Additional corrective action (Required in Full Report and Full Corrective Action Report.) | Action assigned to (name and job title) | Expected completion date (yyyy-mm-dd) | Completed date (yyyy-mm-dd) |
|--|--|--|--------------------------------|
| a) | | | |
| b) | | | |
| c) | | | |
| d) | | | |

18. Persons who carried out or participated in the full investigation

| Representative | Name | Job title | Signature (optional) | Date signed (yyyy-mm-dd) |
|---------------------------------------|------|-----------|----------------------|-----------------------------|
| Employer representative (required) | | | | |
| Worker representative (required) | | | | |
| Other | | | | |

19. Other relevant workplace parties

| Company name | Contact person | Contact number or email address |
|--------------|----------------|---------------------------------|
| a) | | |

End of report

Completing all the sections above satisfies the requirements for a Full Investigation Report and a Full Corrective Action Report.

Employers are required to submit **full** investigation reports to WorkSafeBC **within 30 days* of the incident**. Reports may be submitted by fax to 604.276.3247 (Greater Vancouver), toll-free fax 1.866.240.1434, or by mail to PO Box 5350, Stn Terminal, Vancouver BC V6B 5L5. Do **NOT** submit a preliminary report unless you have been so directed by a WorkSafeBC officer.

* Employers can request an extension from a WorkSafeBC officer, **if the full investigation cannot be completed within 30 days**.

As of January 1, 2016, copies of **all** reports must also be provided to the joint occupational health and safety committee or worker representative, as applicable.