



Occupational Health & Safety and Staff Abuse **REPORT FORM**

Immediately file this form with your Local Union. Keep the pink 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

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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 • January 2012 • KLU • CEP