

Provide the following information IMMEDIATELY by calling 1 800 999-9775.

SECTION A: Employer information				
Company name:		Name of person reporting:		
Address:		Telephone:		
Contact person:		Workplace name/address:		
Telephone:				
SECTION B: Incident being reported				
<input type="checkbox"/> Loss of consciousness	Exposure		Details:	
<input type="checkbox"/> Amputation	<input type="checkbox"/> Biological			
<input type="checkbox"/> Fracture (other than fingers or toes)	<input type="checkbox"/> Chemical			
<input type="checkbox"/> Burn requiring medical attention	<input type="checkbox"/> Physical			
<input type="checkbox"/> Loss of vision in eye(s)	<input type="checkbox"/> Explosion			
<input type="checkbox"/> Deep laceration requiring medical attention	<input type="checkbox"/> Catastrophic event			
<input type="checkbox"/> Admission to hospital by a physician	<input type="checkbox"/> Catastrophic equipment failure			
<input type="checkbox"/> Death				
SECTION C: Description of incident				
Date/time of incident:		Operation/location:		
Location (nearest city/town):				
<b>Preliminary incident details:</b>				
SECTION D: For incidents/events with injuries				
Name of injured:		Injured taken to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Occupation:		Name of hospital:		
Approximate age:	Telephone:			
<b>Nature of injuries:</b>				
SECTION E: For exposures – record of sampling				
Performed by:				
Agent	Location	Time	Results	Comments