

On Line Incident Reporting

Employee Incident Entry Guide

Revised May 4, 2016



**Employees will be provided
with a web link to access the
Employee Incident Report**

**They will use their First Name,
Last Name and Date of Birth to
access a blank incident report**



Introduction

Use this form to report a work related incident or accident. Please ensure that you report an incident as soon as it is feasibly possible as incidents causing injury must be reported immediately by [your company name] to the provincial worker compensation board.



Company Logo
Here

To reduce subsequent follow-up, we encouraged that all information be completed accurately and in detail. Any information, on the following pages, with a red title is mandatory and must be completed before you may submit the form.

If you need assistance please call [555-555-555].

Click on Lookup

Employee Details

Employee Name:  Lookup

Job Class / Position

City


Birth Date

Introduction

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To reduce subsequent follow-up information, on the form, please provide as much information as possible. If you need assistance please contact your supervisor.

Employee Details

Employee Name: 

Job Class / Position:


Reporting Information


Supervisor:

Employee Lookup

First Name:

Last Name:

Birth Date (YYYY/MM/DD)
 

 Please complete all fields to find your employee record

If your name has accented characters, please type your name without the accents.

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To reduce subsequent follow-up, please provide as much information as possible. Any information, on the form, that is not applicable, please leave blank. If you need assistance please contact your supervisor.

Employee Details

Employee Name:

Job Class / Position:

Reporting Information

Supervisor:

Employee Lookup

First Name:

Last Name:

Birth Date (YYYY/MM/DD)

Click on Search →

Please complete all fields to find your employee record

If your name has accented characters, please type your name without the accents.

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To reduce subsequent follow-up, please provide any information, on the form, that you have available. If you need assistance please contact your supervisor.

Employee Details

Employee Name:

Job Class / Position:

Reporting Information

Supervisor:

Employee Lookup

1 person was found. Displaying page 1 of 1

First Name: <input type="text" value="Brittany"/>	BRITTANY SCHNIEDER
Last Name: <input type="text" value="Schnieder"/>	ADMIN - ASSOCIATE
Birth Date (YYYY/MM/DD) <input type="text" value="1981/12/23"/> <input type="button" value="Calendar"/>	

Click on the name to open a blank incident

Introduction

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Company Logo

Here

To re
Any in
If you

**Any field heading
in red must be
completed**

Emp
Empl

Rep

Please provide your contact information below

Your Telephone Number:

Your Email Address:




Introduction

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Employee Details

Employee Name:  Lookup

Job Class / Position

City

Birth Date

Reporting Information


Supervisor

Please provide your contact information below

Your Telephone Number:

Your Email Address: x

Enter your Supervisor,
Phone Number &
Email Address



Introduction

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Any

If yo

Using the scroll bar at the right of the screen, move down and continue completing the web form

Em

Emp

Re

Please provide your contact information below

Your Telephone Number:

Your Email Address: x

Read and select an
Incident Type

Incident Description

Incident Type

- I am reporting a hazard situation where there was no personal injury
- I was injured. I did not receive first aid or, I received first aid from someone other than a physician or other health care professional. I returned or will be returning to work.
- I was injured. I received medical attention at a hospital or at a medical clinic or at a doctor's office. I returned or will be returning to work.
- I was injured and I will be off from work as the result of my injuries.

Date of Incident

Time

Enter Date and
Time of Incident

Incident Details

Witness(es) of Incident

Click and Add
a Witness

Incident Details

Witness(es) of Incident


Name:

Address:

Telephone Number

Incident Details

Witness(es) of Incident

 Add a Witness


Incident Details


Witness(es) of Incident

Name:

Address:

Telephone Number

 Delete Witness

 Add a Witness

Click and Add a
second Witness


Incident Details

Witness(es) of Incident

Name:

Address:


Telephone Number

 Delete Witness

Name:

Address:

Telephone Number

 Delete Witness

Click the dropdown
to see available
Location choices

Location where incident occurred

Location where incident occurred

- Receiving Dock 1
- Receiving Dock 2
- Receiving Dock 3
- Receiving Dock 4
- Mail Room Stn. 1 - Outgoing
- Mail Room Stn. 2 - Incoming
- Patient Room

of this incident?
(part, etc., provide more detail)

Location where incident occurred

Receiving Dock 4

What were you doing at the time of this incident?
(ex. cutting open a box, pushing cart, etc., provide more detail)

I was restocking shelves with product

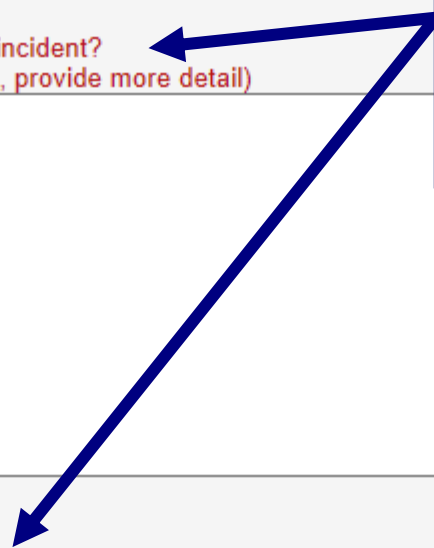
You have 923 characters left

What happened to cause this incident?
(Contributing factors related to people, process, equipment, materials, and environment)

I was bending, lifting and twisting repetitively to move product from pallet to shelf

You have 875 characters left

Click in text boxes to
answer Incident
questions



Provide all additional details that are relevant or significant.

Examples:

- Description and weight being lifted or moved (kg or lbs)
- How long was the task being performed on the day of the injury?
- How long was the task performed in the last hour leading up to the reported injury?
- Was there a specific incident to cause the injury?

I was transferring bags of dog food - they were 50 kg - unloaded 2 pallets over the course of 1 hour - approximately 80 bags

You have 836 characters left

Click in text box to provide additional Incident details



If this is a Hazard, the Submit button appears following this question

**If this is a First Aid, Health Care or Lost Time,
the User must complete additional
information prior to submission**

Injury Details

Describe your Injury:

Click dropdown to
see available
Injury choices

Injury Details

Describe your Injury:

- SPRAIN/STRAIN
- BURN
- ABRASION/SCRATCH
- BROKEN TEETH
- DISLOCATION
- FRACTURE
- ILLNESS
- BITE (INSECT/HUMAN)
- BRUISE/CONTUSION
- BURN
- ELECTRICAL SHOCK
- BREATHING DIFFICULTY

ply):

- Elbow
- Forearm
- Wrist

- Teeth
- Neck
- Chest
- Upper Back

- | Left | Right |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

- Lower Back
- Adbomen
- Pelvis

- | Left | Right |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Click on a check box
to indicate the
injured body part

Injury Details

Describe your Injury:

SPRAIN/STRAIN

Affected Areas (check all that apply):

- Head
- Face
- Eye(s)
- Ear(s)

- Teeth
- Neck
- Chest
- Upper Back

- Lower Back
- Adbomen
- Pelvis

Left Right

- Shoulder
- Arm
- Elbow
- Forearm
- Wrist

Left Right

- Hand
- Fingers
- Hip
- Thigh
- Knee

Left Right

- Lower Leg
- Ankle
- Foot
- Toes

Indicate whether Medical Treatment was sought --
If "No", click "Submit"

Medical

Did you seek medical treatment?

Yes No Unknown

Submit

If "Yes", click where
Treatment was received
and click "Submit"

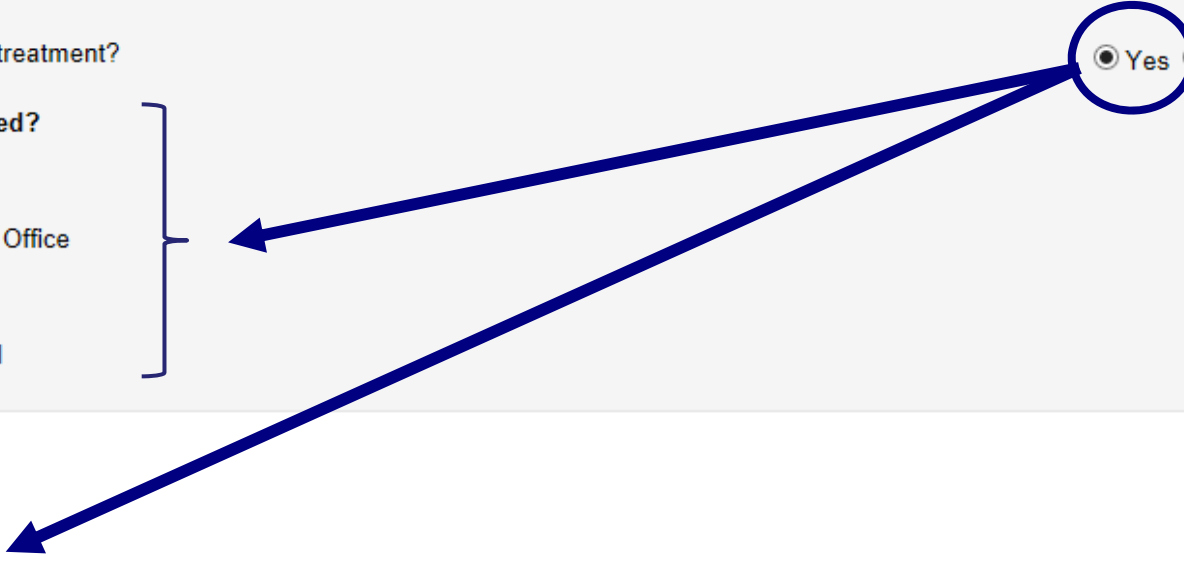
Medical

Did you seek medical treatment? Yes No Unknown

Where were you treated?

- On Site Clinic
- Ambulance
- Health Professional Office
- Medical Clinic
- Emergency
- Admitted to Hospital

Submit



When required fields have not been completed, an error message will appear and the missing fields will highlight

Incident Description

Incident Type

- I am reporting a hazard situation where there was no personal injury
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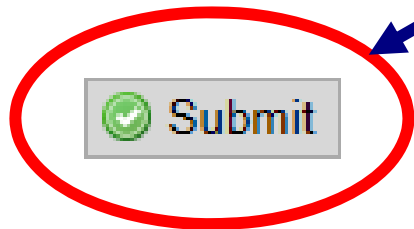
Date of Incident

Time



You missed 1 field. Please correct and try again


Scroll through the form and correct any errors and resubmit the incident





Submission Complete

Your submission ID is **3773**

This report has now been submitted. You can either print a copy of the submitted report, or return to the home page.

 Print Report

 Start a New Report

 Home Page

Print a copy of the report for reference, if required

An Employee has Submitted an Incident Report

The Parklane System [noreply@parklanesys.com]

Extra line breaks in this message were removed.

Sent: Wed 5/4/2016 11:45 AM

To: **Support Email**

Cc: Sara Kane

An Employee Incident Report has been submitted and requires completion.

Please complete the report using the following URL:

<http://pkstc/HD-Supervisor/index.php?employeeReport=3773>

NOTE: This incident will be available in the Parklane System after it has been retrieved and submitted using the Supervisor Incident Report.

Company: 010 - Parklane Demo Data Karen/Claudette
Employee Name: SCHNIEDER, BRITTANY
Department: ADMIN, Administration
Employee Key: 128
Date of Incident: 04 May 16
Type of Incident: Lost Time
Injury: SPRAIN/STRAIN

Employee Contact Information:

Name: BRITTANY SCHNIEDER

Phone: 519 433-9876

Ext:

E-mail: c.everitt@parklanesys.com

Date/Time of Entry: 04 May 16 at 11:44

This confidential message was automatically generated by the Parklane System.

Please do not respond to this message.

Once submitted, an
email is issued to
assigned Users for
follow up

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Employee Incident Entry Guide

END

