simcoe muskoka
DISTRICT HEALTH UNIT

Near Miss

This form is used when a work-related incident occurs and the employee:

- **Receives first aid only (see definition Appendix D)**
- **Receives first aid and requires modified work at regular pay for less than 7 calendar days**
- **Does not receive first aid but requires modified work at regular pay for less than 7 calendar days**

Section A Employee Information

Last Name:	First Name:	
Service:	Program:	Office:

Section B Report (to be completed by employee)

Describe Incident: *(use other side as needed)*

Factors Contributing to Incident:

Employee's Signature:	Date:

Section C Manager/Supervisor Information

Last Name:	First Name:

Manager/Supervisor Response (within 21 days):
(use other side as needed)

Manager/Supervisor Signature:	Date:

Original to: Manager/Supervisor
Copy to: Human Resources Advisor
Employee