



Principal/Supervisor's Incident Report

INSTRUCTIONS TO SUPERVISOR/PRINCIPAL:

1. **If this is a critical injury** (Definition: places life in jeopardy, causes a broken arm or leg (but not finger or toe), results in heavy blood loss, produces unconsciousness, loss of sight in one or both eyes, or produces widespread burns, please report to the Manager of Human Resources **IMMEDIATELY**
2. **Plant Supervisor** completes this report for custodial/maintenance employees and **Principal** completes for all others.
3. Please conduct an independent investigation when completing this report. Your investigation should include an interview with the injured worker and a physical investigation of the accident site before completing this report. **PLEASE FAX to Human Resources Department (705) 267-3590 within 24 hours of accident!**
4. ***Please involve the Health & Safety Representative for your workplace in your investigation***

SECTION 1

Employee Name: _____		ID/SIN#: _____
Work Location: _____		
Date & Time of Accident/Illness:	Date _____	Time: _____
Date & Time Reported:	Date _____	Time: _____
Reported to: (Name and Position): _____		

SECTION 2

<p>LOST TIME - NO LOST TIME</p> <p>Please choose ONE - After day of accident/awareness of illness, this employee:</p> <p>Returned to regular job and has NOT lost any time and/or earnings Returned to modified job and has NOT lost any time and/or earnings Has lost time and/or earnings - complete below</p> <p>First Day of Lost Time: _____</p> <p>Date Back to Work: _____</p> <p>Regular/Modified: _____</p> <p>Was the worker offered Modified Duties? If not, please explain why _____</p>

SECTION 3

<p>HEALTH CARE:</p> <p>Did employee receive health care for this injury? Yes No If yes, please indicate when: _____</p> <p>Date that the School Board learned that the employee received health care: _____</p> <p>Where was the worker treated for this injury? (Check all that apply)</p> <p>On-site health care Ambulance Emergency Dept. Admitted to Hospital Clinic Health Professional Office (Doctor/Dentist/Chiropractor/Physiotherapist)</p> <p>Name, Address and Phone number of health professional (if known) _____</p> <p>_____</p>
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SECTION 4

DESCRIPTION OF ACCIDENT

Explain what happened to cause accident/illness and what the worker was doing at the time. Describe the injury and provide any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have been involved. If a condition that occurred gradually developed over time, please explain how it developed:

SECTION 5

TYPE OF ACCIDENT/ILLNESS (PLEASE CHECK ALL THAT APPLY):

- | | | |
|---|--|--|
| <input type="checkbox"/> 1 Struck or Contact By | <input type="checkbox"/> 2 Struck Against/Contact with | <input type="checkbox"/> 3 Fall |
| <input type="checkbox"/> 4 Slip/No Fall | <input type="checkbox"/> 5 Caught In/under/on/between | <input type="checkbox"/> 6 Exposure |
| <input type="checkbox"/> 7 Over Exertion/Strain | <input type="checkbox"/> 8 Repetitive Body Movement | <input type="checkbox"/> 9 Traumatic Event |
| <input type="checkbox"/> 10 Aggression | <input type="checkbox"/> 11 Insufficient Information | <input type="checkbox"/> 12 Other _____ |

CAUSES:

- | | |
|--|---|
| <input type="checkbox"/> 1 Operating without Authority | <input type="checkbox"/> 3 Unsafe Loading, Placing, Mixing, Combining, etc. |
| <input type="checkbox"/> 2 Unsafe Equipment | <input type="checkbox"/> 5 Distracting, Teasing, Wilful Misconduct |
| <input type="checkbox"/> 4 Unsafe Position or Posture | <input type="checkbox"/> 7 Inadequate Illumination |
| <input type="checkbox"/> 6 Failure to use Personal Protective Devices | <input type="checkbox"/> 9 Hazardous Personal Attire |
| <input type="checkbox"/> 8 Fire, Explosion, Atmospheric Hazard | <input type="checkbox"/> 11 Hazardous Method or Procedure |
| <input type="checkbox"/> 10 Unsafe Design or Arrangement | <input type="checkbox"/> 13 Improperly Labelled or Identified |
| <input type="checkbox"/> 12 Outside Hazardous Condition | <input type="checkbox"/> 15 Inadequate Clearance, workspace |
| <input type="checkbox"/> 14 Improper Ventilation | <input type="checkbox"/> 17 Inadequate Help |
| <input type="checkbox"/> 16 Inadequate Tools or Equipment | <input type="checkbox"/> 19 Making Safety Devices Inoperable |
| <input type="checkbox"/> 18 No Hazard | <input type="checkbox"/> 21 Inadequate Housekeeping |
| <input type="checkbox"/> 20 Inadequate Maintenance | <input type="checkbox"/> 23 Inattention |
| <input type="checkbox"/> 22 Failure to Follow Established Procedures, Rule | <input type="checkbox"/> 25 Other _____ |
| <input type="checkbox"/> 24 Physical Condition | |

WITNESSES:

Was any individual not working for the School Board partially or totally responsible for this accident/illness?

Yes No

If **yes**, provide name, phone #, and employer's name: _____

AREA OF INJURY (BODY PART) (Please check all that apply):

- | | | | | |
|----------------|-------------|----------------|------------|-------------|
| 708 Head | 731 Face | 701 Eye(s) | 703 Ear(s) | 704 Teeth |
| 709 Neck | 714 Chest | 721 Upper Back | 728 Hip | 715 Abdomen |
| 723 Lower Back | Other _____ | | | |

PLEASE INDICATE LEFT OR RIGHT:

- | | | | | | | | | |
|------------------|------|-------|------------------|------|-------|--------------|------|-------|
| Shoulder | Left | Right | Arm | Left | Right | Elbow | Left | Right |
| Forearm | Left | Right | Wrist | Left | Right | Hand | Left | Right |
| Finger(s) | Left | Right | Hip | Left | Right | Thigh | Left | Right |
| Knee | Left | Right | Lower Leg | Left | Right | Ankle | Left | Right |
| Foot | Left | Right | Toe(s) | Left | Right | | | |

WHERE INJURY OCCURRED:

- | | | |
|---|--|--|
| <input type="checkbox"/> 740 Outdoor walkways | <input type="checkbox"/> 742 Classroom | <input type="checkbox"/> 746 Hallway |
| <input type="checkbox"/> 747 Indoor foyer/entrance/exit | <input type="checkbox"/> 754 Office | <input type="checkbox"/> 756 Parking lot |
| <input type="checkbox"/> 757 Playground | <input type="checkbox"/> 760 Stairwell | <input type="checkbox"/> 768 Gymnasium |
| <input type="checkbox"/> 776 Library | <input type="checkbox"/> Other _____ | |

SECTION 6

PRIOR CONDITIONS:

Are you aware of any prior similar/related problem, injury of condition? ? Yes ? No

If **yes**, please explain: _____

SECTION 7

CORRECTIVE & PREVENTATIVE ACTION:

- | | |
|--|--|
| <input type="checkbox"/> 1 Re-instruction of person involved | <input type="checkbox"/> 2 Re-assignment of person |
| <input type="checkbox"/> 3 Order Job Safety Analysis | <input type="checkbox"/> 4 Improved Personal Protective Equipment |
| <input type="checkbox"/> 5 Repair or Replacement | <input type="checkbox"/> 6 Installation of Guard or Safety Device |
| <input type="checkbox"/> 7 Actions to Improve Design/Method | <input type="checkbox"/> 8 Check with Manufacturer |
| <input type="checkbox"/> 9 Discipline of Persons involved | <input type="checkbox"/> 10 Workplace Inspection |
| <input type="checkbox"/> 11 Consult with Health & Safety | <input type="checkbox"/> 12 Consult with Joint Health & Safety Committee |
| <input type="checkbox"/> 13 Consult with Ministry of Labour | <input type="checkbox"/> 14 Incident under Investigation |
| <input type="checkbox"/> 15 Correction of Congested Area | <input type="checkbox"/> 16 Inform All Department Supervision |
| <input type="checkbox"/> 17 Improve Housekeeping Procedure | <input type="checkbox"/> 18 Develop written safe working procedures |
| <input type="checkbox"/> 19 Ergonomic Assessment | <input type="checkbox"/> 20 Develop Inspection Form and Routine |
| <input type="checkbox"/> 21 Provide Proper Ventilation | <input type="checkbox"/> 22 Other _____ |

Describe how the above action(s) have been (or will be) implemented to prevent a recurrence & include timelines:

HEALTH & SAFETY ACTION PLAN:

1. _____

2. _____

3. _____

Principal/Supervisor's Signature _____

Date _____