



EMPLOYEE INCIDENT REPORT

INSTRUCTIONS TO EMPLOYEE:

- Complete form and sign & date below.
- If seeing a medical professional (physician, physiotherapist, or chiropractor), please take *Functional Abilities Form* to your Health Care professional for completion.
- Make sure your Principal/Supervisor completes the Principal/Supervisor Incident Report.
- **FAX TO: Human Resources, within 24 hours of the accident (705) 267-3590**

SECTION 1

Employee Name:	_____	ID/SIN#:	_____
Home Phone:	_____	Job Title/Position:	_____
Date of Birth:	_____	Days Worked per Week:	_____
Work Location:	_____		
Working Hours:	From: _____	To:	_____
Date & Time of Accident/Illness:	Date _____	Time:	_____
Date & Time Reported:	Date _____	Time:	_____
Reported to: (Name and Position)	_____		

SECTION 2

LOST TIME - NO LOST TIME

Please choose ONE - **After day of accident/awareness of illness, did you:**

Return to **regular job** and **NOT** lose any time and/or earnings **OR**

Return to **modified** job and **NOT** lose any time and/or earnings

Lose time and/or earnings - complete below

First day of lost time: _____

Date Back to Work: _____

Did you return to:

Regular work OR Modified duties?

SECTION 3

HEALTH CARE:

Did you receive health care for this injury? Yes No If yes, please indicate when: _____

When did you notify the School Board that you received health care? _____

Where were you treated for this injury? (Check all that apply)

- | | | | |
|-------------------------------|---|-----------------|----------------------|
| On-site health care
Clinic | Ambulance
Health Professional Office (Doctor/Dentist/Chiropractor/Physiotherapist) | Emergency Dept. | Admitted to Hospital |
|-------------------------------|---|-----------------|----------------------|

Name/Address/Phone # of Health Professional: _____

Were you prescribed medications/drugs? Yes No

Were you referred for any other treatment or tests? Yes No

Did you talk to your health care professional about returning to modified/regular work? Yes No

SECTION 4

DESCRIBE what happened to cause accident/illness and what you were doing at the time. Please indicate what the injury is and any details of equipment, materials, environment conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have been involved. If your condition developed over time please explain how it progressed.

SECTION 5

TYPE OF ACCIDENT/ILLNESS (Please check all that apply):

- | | | |
|------------------------|---------------------------------|-------------------|
| 1 Struck or Contact By | 2 Struck Against/Contact With | 3 Fall |
| 4 Slip/No Fall | 5 Caught In, Under, On, Between | 6 Exposure |
| 7 Over Exertion/Strain | 8 Repetitive Body Movement | 9 Traumatic Event |
| 10 Aggression | 11 Insufficient Information | 12 Other _____ |

CAUSES:

- | | |
|--|--|
| <input type="checkbox"/> 1 Operating without Authority | <input type="checkbox"/> 2 Unsafe Equipment |
| <input type="checkbox"/> 3 Unsafe Loading/Placing/Mixing/Combining | <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

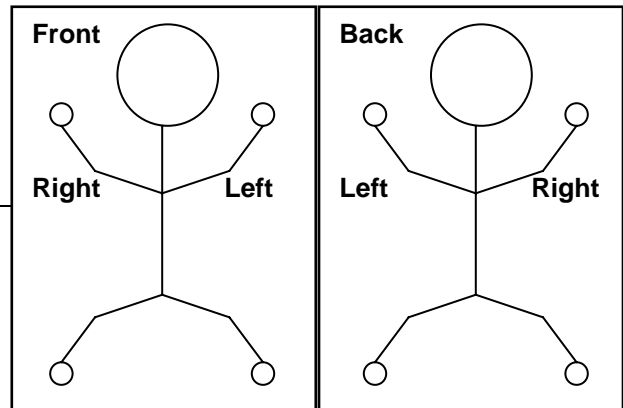
If **yes**, please provide name, phone # and company this person worked for: _____

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 | 723 Lower Back |
| 715 Abdomen | 728 Hip | Other _____ |

Using the diagram to the right, please circle the area of injury



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 or condition? Yes No

If **yes**, please explain: _____

Do you have any prior related WSIB/WCB claims? No Yes - in Ontario Yes - outside Ontario

Dates of prior conditions: _____

If you did not report this to your employer right away, please indicate why: _____

EMPLOYEE'S SIGNATURE

DATE