EMPLOYEE INCIDENT/INJURY REPORT-HR5

INSTRUCTIONS TO EMPLOYEE:

- Complete form, sign & date below.
- If modified work is required and you are seeing a medical professional (physician, physiotherapist or chiropractor), please ensure the Health Care professional completes the Form 8 and provides you with a copy of Page 2
- **Please supply your employer with a copy of Page 2 of the Form 8 immediately if you have received health care treatment.**

FAX TO: Debra Orr, Disability Management Coordinator, Human Resource Services, within 24 hours of the accident at 705-748-9563, please send the original in the courier

EMPLOYEE NAME: ________________________ **JOB TITLE/POSITION:** ________________________

Location Name: ________________________ **Home Phone:** ________________________

DATE OF BIRTH: ________________ **Working Hours: From:**__________ **am / pm** **To:** __________ **am/pm**
dd/mm/yyyy

Date & Time of Accident/Illness: Date ________________ **Time:** ____________ ☐ AM ☐ PM

Date & Time Reported: Date ________________ **Time:** ____________ ☐ AM ☐ PM

Reported to: (Name and Position) ________________________________

LOST TIME - Please contact Debra Orr immediately - **FIRST DAY ABSENT** ________________

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)
❍ Ambulance ❍ Emergency Dept. ❍ Admitted to Hospital ❍ Clinic ❍ Health Professional Office (Doctor/Dentist/Chiro/Physio)

Name/Address/Phone # of Health Professional:

____

____

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

DESCRIBE what happened to cause accident/illness and what you were doing at the time. **Please indicate what the injury is**, **part of body involved and specify LEFT or RIGHT** and any details of equipment, materials, environment conditions that may have been involved. If your condition developed over time please explain how it progressed.

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

❍ Struck or Contact by	❍ Struck Against/Contact with	❍ Fall
❍ Slip/No Fall	❍ Caught In, Under, On, Between	❍ Exposure
❍ Over Exertion/Strain	❍ Repetitive Body Movement	❍ Insufficient Information
❍ **Aggression** ❍ **INTENTIONAL** ❍ **UNINTENTIONAL**		❍ Other ________________

☐ **High Needs/Special Needs Student – FULL NAME :** ________________________

WITNESSES:

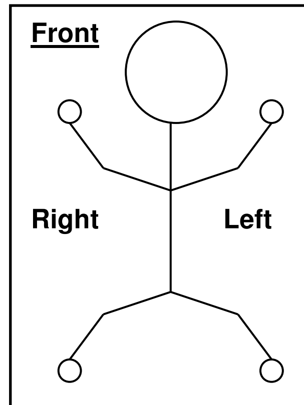
Anyone who **directly** ❍ OR **indirectly** ❍ witnessed the accident, name and phone # ________________________

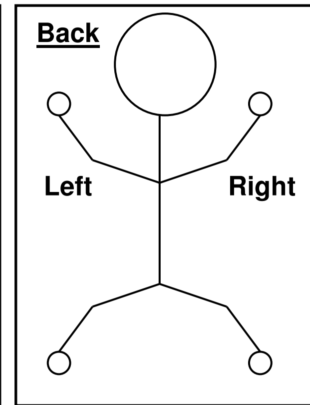
Was any individual not working for the School Board partially or totally responsible for this accident/illness?
❍ Yes ❍ No
If **yes**, please provide name, phone # ________________________________

AREA OF INJURY (BODY PART) Check all that apply

❍ Head	❍ Face	❍ Eye(s)
❍ Ear(s)	❍ Teeth	❍ Neck
❍ Chest	❍ Upper Back	❍ Lower Back
❍ Abdomen	❍ Hip	❍ Other______________

Using the diagram, please circle the area(s) of injury





INJURY Check all that apply

❍ Scratch/Scrape	❍ Bite	❍ Burn
❍ Sprain/Strain	❍ Pinch	❍ Irritation
❍ Muscle Ache	❍ Backache	❍ Swelling
❍ Stiffness	❍ Bruise	

❍ Other **SPECIFY** ____

DID THIS INJURY BREAK THE SKIN? ❍ **YES** (you must contact Debra Orr to complete a "Needlestick Injury' Report) ❍ **NO**

PLEASE INDICATE LEFT OR RIGHT

Elbow	❍ Left	❍ Right	**Foot**	❍ Left	❍ Right	**Knee**	❍ Left	❍ Right
Hand	❍ Left	❍ Right	**Thigh**	❍ Left	❍ Right	**Lower Leg**	❍ Left	❍ Right
Arm	❍ Left	❍ Right	**Ankle**	❍ Left	❍ Right	**Toe(s)**	❍ Left	❍ Right
Shoulder	❍ Left	❍ Right	**Finger(s)**	❍ Left	❍ Right	**Foot**	❍ Left	❍ Right
Wrist	❍ Left	❍ Right	**Forearm**	❍ Left	❍ Right			

WHERE INJURY OCCURRED

Outdoor walkways	Classroom	Hallway
Indoor foyer/entrance/exit	Office	Parking lot
Playground	Stairwell	Gymnasium
Library	Other______________________	

*****DO YOU ALSO HAVE EMPLOYMENT ELSEWHERE? IF SO WHERE** ____

WAGES:____________________**HOURS PER WEEK**:____________**DUTIES:**____

PRIOR CONDITIONS:

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

If **yes**, please explain: ____

If you did not report this to your employer immediately, please indicate why: ____

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Many employees will sustain soft tissue injury which will not require time off. Immediate accommodations are available. Worker's Safety Insurance Board Regulations require that the Board make every reasonable effort to provide suitable alternate employment as not to insure loss time to an employee who is unable to perform his/her normal duties as a consequence of injury, illness or diminished capacity. Please contact Debra Orr, Disability Management Coordinator (705) 748-4861 Ext 235 if you are unable to return to work.

By signing below I am also authorizing my health professional to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the "Functional Ability for Timely Return to Work" form IF REQUIRED.

INFORMATION COLLECTION AUTHORIZATION: The personal information contained on this form has been collected under the Worker's Safety Insurance Act and Municipal Freedom of Information and Protection of Privacy Act, 1989, and may be used to administer potential Worker's Safety Insurance Safety claims. This information will be retained in the Human Resource Services Department – HRIS Office. Any questions with respect to this information should be directed to the HRIS Officer. Users: Supervisory Officers, Human Resource Services Staff

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EMPLOYEE'S SIGNATURE **DATE**

Failure to co-operate - Section 43 (7) (b) of the Workplace Safety & Insurance Act states;

(7) **The Board may reduce or suspend payments to the worker during any period when the worker is not co-operating,**

(a) in health care measures;

(b) in his or her early and safe return to work; or

(c) in all aspects of a labour market re-entry assessment or plan provided to the worker. 1997, c. 16, Sched. A, s. 43 (7).