NORTHEASTERN CATHOLIC DISTRICT SCHOOL BOARD
www.ncdsb.on.ca

101 Spruce St. North
Tmmins, ON P4N 6M9
Tel: (705) 268-7443
Fax: (705) 267-3590

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 Ambulance Emergency Dept. Admitted to Hospital
Clinic Health Professional Office (Doctor/Dentist/Chiropractor/Physiotherapist)

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.

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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:

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

WITNESSES: ______________________________ ______________________________

Was any individual not working for the School Board partially or totally responsible for this accident/illness?
Yes No

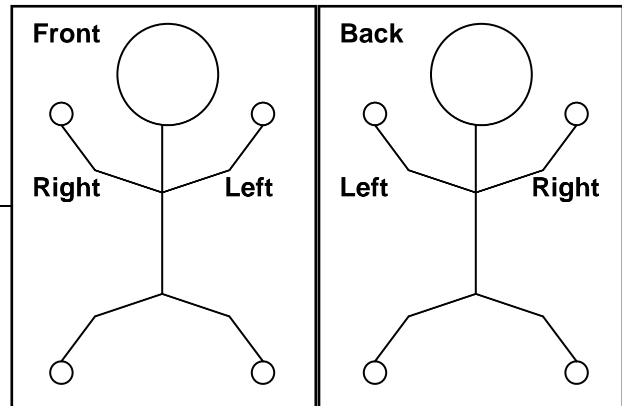
If **yes**, please provide name, phone # and company this person worked for:______________________________

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:

□ 740 Outdoor walkways	□ 742 Classroom	□ 746 Hallway
□ 747 Indoor foyer/entrance/exit	□ 754 Office	□ 756 Parking lot
□ 757 Playground	□ 760 Stairwell	□ 768 Gymnasium
□ 776 Library	□ Other______________	

SECTION 6

PRIOR CONDITIONS:

Are you aware of any prior similar/related problem, injury of 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: ______________________________

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______________________________ ______________________________

EMPLOYEE'S SIGNATURE **DATE**