Northeastern Catholic District SCHOOL BOARD

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?

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

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.

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?
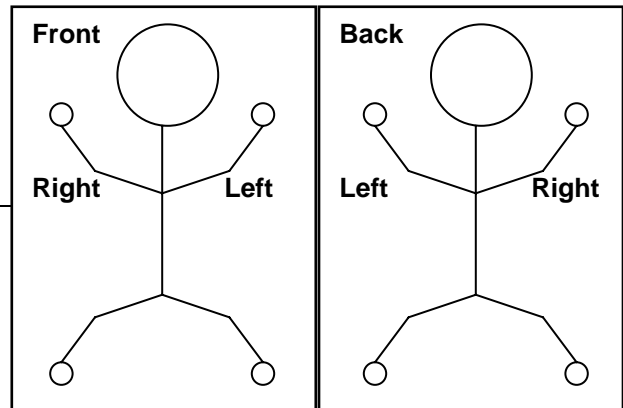   Yes   No

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

Front   **Back**

Right   **Left**   **Left**   **Right**

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: _____

_____

_____

EMPLOYEE'S SIGNATURE   **DATE**