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 <u>within 24 hours of accident</u>!**
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

LOST TIME - NO LOST TIME

Please choose ONE - **After day of accident/awareness of illness, this employee:**

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

First Day of Lost Time: ____

Date Back to Work: ____

Regular/Modified: ____

Was the worker offered Modified Duties? If not, please explain why________________________________

SECTION 3

HEALTH CARE:

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

Date that the School Board learned that the employee received health care: _______________________________

Where was the worker 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 and Phone number of health professional (if known) ____________________________________

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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:

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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, etc.
□ 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**, 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 OCCURRERD:

□ 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:____

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SECTION 7

CORRECTIVE & PREVENTATIVE ACTION:

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

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

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____

HEALTH & SAFETY ACTION PLAN:

____

1. ____

2. ____

3. ____

______________________________ ______________________________

Principal/Supervisor's Signature **Date**