



Workers Accident / Incident / Occupational Illness Report

This form must be completed in its entirety and FAXED to EMPLOYEE WELLNESS within 24 hours

Please call 613-596-8250 for assistance – FAX: 613-596-8798

A: Accident/Incident Type

- incident-No injury, Health Care, Minor Injury-No Treatment, Lost Time, First Aid, Occupational Illness

B: Worker Information

Last Name: First Name: EIN: Date of Birth: Sex: Male Female Do you currently have more than one job? Home Address: City: Postal Code: Home Phone: Work Phone: Cell Number: Work Location (Name of School): Occupation: Immediate Supervisor: Phone:

C: Reporting of Accident or Occupational Illness

Date of Incident: Time of Injury: am pm OR Did condition develop over time? Hours worked on day of injury: From To Regular working hours: From To Date reported: Time: am pm Accident reported to: If there was a delay in reporting accident, list reason(s):

Did you receive health care for this accident/incident? yes no If yes, provide name, phone number, address and appointment date of attending health care professional or hospital.

Did the injury occur on the employer's premises? yes no If yes, Accident location: If no, Accident location: (i.e. Gym, Classroom, yard etc.) Was the work you were doing for the purpose of your employer? yes no If yes, was it part of your usual work? yes no

D: PLEASE INDICATE AREA OF INJURY (Left/Right) Please [X] all that apply:

Head, Eye(s), Face, Ear(s), Teeth, Neck, Chest, Upper Back, Lower Back, Pelvis, Abdomen, Other, Shoulder, Forearm, Finger(s), Knee, Foot, Arm, Wrist, Hip, Lower leg, Toe(s), Elbow, Hand, Thigh, Ankle, Other

Accident Details

Describe fully what happened to cause this injury or illness. Describe what you were doing and include any tools, equipment, materials, etc. Be specific of weights and size of objects. State any gas, chemicals or extreme temperatures you may have been exposed to. If necessary attach additional information. Describe the accident in detail:

Last Name: _____ First Name: _____

Activity or task being performed at time of injury: _____

Materials (weight and size) and or Equipment (type) being handled: _____

Were you provided with Personal Protective Equipment: yes no Were you wearing it: yes no

If yes, please describe: _____

Environment: _____

Witnesses:
Name _____ Occupation _____ Phone _____

Name _____ Occupation _____ Phone _____

Have you had a similar injury or disability? yes no If yes, Please specify: _____

Complete the following if lost time or modified duties will be a result of the above accident:

F: Lost time/Modified duties:

Note: all lost time must be authorized by a Health Care Professional.

Will there be lost time beyond the date of injury? yes no

Date and time last worked: Date _____ Hour _____ am pm

Date and time returned to work: Date _____ Hour _____ am pm

Have you returned to regular work or modified work? regular modified

If you have not returned to work, give expected return to work date: _____

G: Worker's Declarations and Signature:

By signing below you declare all the information provided on this report is true and accurate.

If you are claiming benefits (either health care and/or lost time) under the Workplace Safety and Insurance Act your signature below allows your health care practitioner to release information about your functional abilities directly to your employer and to the WSIB. It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. You understand that there is a Modified Work Program available immediately.

Worker's Signature: _____ Date: _____

H: Supervisor/Principal Signature:

Immediate steps to prevent reoccurrence:

By signing below I declare that the information provided in this report is accurate to the best of my knowledge. I am aware if there are concerns or information not contained in this report that I am to contact the WSIB Administrator at 613- 596-8250.

Supervisors Signature: _____ Date: _____