ACCIDENT INVESTIGATION REPORT – FOR STAFF INJURIES

TO BE COMPLETED BY SUPERVISOR/PRINCIPAL

INTENT OF THE FORM:

This form is intended to provide information regarding workplace accidents or occupational disease, accident trends and to provide targets for corrective action. The information provided will also be used to fulfill reporting obligations under the authority of the Workplace Safety and Insurance Act. The long term effects should be: improved Occupational health, reduction in the number of accidents and a healthier and safer workplace.

INSTRUCTIONS:

Complete within 2 working days and submit to the Benefits & Compensation Department, CEC. If this is a fatality, *critical injury, or is fire/explosion related, IMMEDIATELY PHONE the Occupational Health & Safety Department at extension 2665/2674.

PART A/B GENERAL INFORMATION/INJURED WORKER IDENTIFICATION
(Self explanatory)

PART C INJURY INVESTIGATION
- describe clearly how the worker states the accident occurred.
- state the activity at the time of the incident (e.g. walking to portable and why).
- give exact location (e.g. doorway, room number, etc.)
- explain main causes which contributed to the incident (e.g. weather conditions, degree of haste, lack of access, visibility)

TYPE OF CLAIM
- check "Lost Time" if the person does not return by the next work day following the injury

TREATMENT HISTORY
- check only one option and provide Doctor's name or Hospital as applicable.

PART D WSIB CLAIM INFORMAITON
- answer questions to the best of your knowledge while providing any additional information relevant to the incident.

PART E PREVENTIVIE ACTION
- indicate action taken or intended to prevent a similar accident from occurring.

PART F AUTHORIZATION
- it is required that the Supervisor/Principal sign and date form after completion.

PART G RECURRENCE
- answer questions to the best of your knowledge while providing any additional information relevant to the incident.

DISTRIBUTION:

To be returned to the Benefits & Compensation Department at the C.E.C. Please FAX to (416) 229-7051. A photocopy should be retained for the school/department files.

Note: *The personal information on this form is collected under the authority of the Occupational Health and Safety Act Sections 51, 52 and 53, Section 5 of the Industrial Regulations and Section 21 of the Workplace Safety and Insurance Act. Questions should be directed to the Senior Manager, Benefits & Compensation Department, Toronto Catholic District School Board, (416) 222-8282, ext. 2643.*

**Critical Injury* *is defined as an injury of a serious nature that places life in jeopardy, produces unconsciousness, results in substantial loss of blood, involves the fracture of a leg or arm, involves the amputation of a leg, arm, hand or foot, consists of burns to a major portion of body or causes the loss of sight in an eye.*

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TO BE COMPLETED BY SUPERVISOR/PRINCIPAL

A – GENERAL INFORMATION

LOCATION #	SCHOOL/DEPT. NAME	POSTAL CODE	WORKER SOCIAL INSURANCE NO.

B – INJURED WORKER IDENTIFICATION

LAST NAME	FIRST NAME	SEX	AREA CODE	PHONE NO.	DATE OF BIRTH (DD.MM.YY) / /

ADDRESS	CITY, TOWN	POSTAL CODE

OCCUPATION AT TIME	NORMAL HOURS OF WORK	DATE OF HIRE (DD.MM.YY) / /	YEARS EXPERIENCE IN OCCUPATION

C – INJURY INVESTIGATION

TYPE OF CLAIM:

- RECURRENCE ☐ NO NEW INJURY – ONGOING PROBLEMS FROM OLD INJURY
- FIRST AID ☐ NO LOST TIME, NO MEDICAL TREATMENT SOUGHT
- HEALTH CARE ☐ NO LOST TIME, MEDICAL TREATMENT SOUGHT
- LOST TIME ☐ (EMPLOYEE WAS OFF WORK AT LEAST ONE DAY FOLLOWING DAY OF ACCIDENT)

IF LOST TIME, DATE & HOUR LAST WORKED ☐ AM ☐ PM

If this is a Recurrence, complete section G only. If this is a First Aid, DO NOT complete name and address of family physician or treatment history.

TIME & DATE OF ACCIDENT		(DD,MM,YY)	TIME & DATE REPORTED TO SUPERVISOR		(DD,MM,YY)
	☐ AM ☐ PM	/ /		☐ AM ☐ PM	/ /

NAME & ADDRESS OF FAMILY PHYSICIAN:

TREATMENT HISTORY:

WHERE WAS INITIAL MEDICAL ATTENTION SOUGHT? (Give name and address):

DATE OF INITIAL TREATMENT:

Describe clearly how the worker states the accident occurred. If the injury was not reported immediately, give reasons:

What happened to cause the injury?

Explain what the worker was doing, the effort involved and how it pertains to the purpose of the worker's job:

Identify the size, weight and type of equipment or materials involved:

Describe injury, part of body involved and specify left or right side:

Where did the accident occur?

C – INJURY INVESTIGATION CONT'D

What conditions contributed to the accident:

Give names of witnesses:

Give names of persons having knowledge of the injury:

D – WSIB CLAIM INFORMATION

	YES	NO
1. Was any individual not employed by the TCDSB totally or partially responsible for the accident?	☐	☐
2. Do you have any reason to doubt the history of the injury?	☐	☐
3. At time of injury, was the worker doing work OTHER THAN for the purpose of the employer's business?	☐	☐
4. Was there any serious and willful misconduct involved?	☐	☐
5. To your knowledge, has the worker had a previous similar disability?	☐	☐
6. Do you have information that the worker could have returned to work earlier?	☐	☐

Note: Explain "YES" answers in an attached letter if necessary.

E – PREVENTIVE ACTION

State clearly what steps were/will be taken to prevent this incident from occurring again (please give date of completion/intended date of completion):

F – AUTHORIZATION

DATE

SIGNATURE OF SUPERVISOR

The Supervisor/Principal must report the employee's return-to-work date (if applicable). Please call the Benefits & Compensation Department at (416) 222-8282, ext. 2065.

CONTINUED ON BACK

G – RECURRENCE

If this accident is a recurrence, please answer the following questions.

Provide details and claim # of original injury:

What happened to cause the worker to stop working and/or see the doctor at this time?

Describe the conditions of the worker's injury since he/she last returned to work:

Since the worker last returned to work, has he/she complained to you or any co-worker about ongoing problems? If yes, provide names and details:

Has the worker been able to perform his/her regular job since returning to work? If not provide details:

Since the worker's last return to work, has he/she continued to see a doctor for this disability? If yes, provide details:

DATE

SIGNATURE OF SUPERVISOR

The Supervisor/Principal must report the employee's return-to-work date (if applicable). Please call the Benefits & Compensation Department at (416) 222-8282, ext. 2065.

FOR BOARD USE ONLY:

DAILY RATE OF PAY:	$	TOTAL WEEKLY PAY HOURS:	
HOURLY RATE OF PAY:	$	NET CLAIM FOR EXEMPTION:	
		NET CLAIM CODE:	

STAFF DIRECTORY

Senior Manager, Benefits & Compensation	*2643*
Return to Work Officer, Workers' Compensation	*2065*
Officer, Benefits and WSIB Services	*2319*
Clerk, Benefits and WSIB Services	*2716*