OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

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 ❑ Minor Injury-No Treatment ❑ First Aid
❑ Health Care ❑ Lost Time ❑ Occupational Illness

B: Worker Information

Last Name:_____ First Name:_____

EIN: _____Date of Birth:_____

Sex:____Male ____Female Do you currently have more than one job? ❑ yes ❑ no

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?_____ ❑ yes ❑ no

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, Acccident 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 ☒ all that apply):

❑Head ❑ Eye(s) ❑ Face ❑ Ear(s) ❑ Teeth ❑ Neck
❑ Chest ❑ Upper Back ❑ Lower Back ❑ Pelvis ❑ Abdomen ❑ Other _____

Shoulder	L ❑	R ❑	Arm	L ❑	R ❑	Elbow	L ❑	R ❑
Forearm	L ❑	R ❑	Wrist	L ❑	R ❑	Hand	L ❑	R ❑
Finger(s)	L ❑	R ❑	Hip	L ❑	R ❑	Thigh	L ❑	R ❑
Knee	L ❑	R ❑	Lower leg	L ❑	R ❑	Ankle	L ❑	R ❑
Foot	L ❑	R ❑	Toe(s)	L ❑	RL ❑	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: _____

OTTAWA-CARLETON DISTRICT SCHOOL BOARD – ABILITIES FORM (2 pages)

Employee Group:	***Requested By:***
WSIB Claim: ☐ ***Yes*** ☐ ***No***	***WSIB Claim Number:***

To the Employee: The purpose for this form is to provide the Board with information to assess whether you are able to perform the essential duties of your position, and understand your restrictions and/or limitations to assess workplace accommodation if necessary.

Employee's Consent: I authorize the Health Professional involved with my treatment to provide to my employer this form when complete. This form contains information about any medical limitations/restrictions affecting my ability to return to work or perform my assigned duties.

Employee Name: *(Please print)*	**Employee Signature:**
Employee ID:	**Telephone No:**
Employee Address:	**Work Location:**

1. Health Care Professional: The following information should be completed by the Health Care Professional

Please check one:

☐ Patient is capable of returning to work with no restrictions.

☐ Patient is capable of returning to work with restrictions. **Complete section 2 (A & B) & 3**

☐ I have reviewed sections 2 (A & B) and have determined that the Patient is totally disabled and is unable to return to work at this time. **Complete sections 3 and 4. Should the absence continue, updated medical information will next be requested after the date of the follow up appointment indicated in section 4.**

First Day of Absence: _____	General Nature of Illness (***please do not include diagnosis***): _____

Date of Assessment:
dd mm yyyy

2A: Health Care Professional to complete. Please outline your patient's abilities and/or restrictions based on your objective medical findings.

PHYSICAL (if applicable)

Walking:	**Standing:**	**Sitting:**	**Lifting from floor to waist:**
☐ Full Abilities	☐ Full Abilities	☐ Full Abilities	☐ Full Abilities
☐ Up to 100 metres	☐ Up to 15 minutes	☐ Up to 30 minutes	☐ Up to 5 kilograms
☐ 100 - 200 metres	☐ 15 - 30 minutes	☐ 30 minutes - 1 hour	☐ 5 - 10 kilograms
☐ Other (*please specify*):	☐ Other (*please specify*):	☐ Other (*please specify*):	☐ Other (*please specify*):

Lifting from Waist to Shoulder:	**Stair Climbing:**	☐ **Use of hand(s):**	
		Left Hand	**Right Hand**
☐ Full abilities	☐ Full abilities	☐ Gripping	☐ Gripping
☐ Up to 5 kilograms	☐ Up to 5 steps	☐ Pinching	☐ Pinching
☐ 5 - 10 kilograms	☐ 6 - 12 steps	☐ Other (*please specify*):	☐ Other (*please specify*):
☐ Other (*please specify*):	☐ Other (*please specify*):		

☐ **Bending/twisting** repetitive movement of (*please specify*):	☐ **Work at or above shoulder activity:**	☐ **Chemical exposure to:**	**Travel to Work:** Ability to use public transit _____ Ability to drive car	☐ Yes ☐ No _____ ☐ Yes ☐ No

Ottawa-Carleton District School Board
133 Greenbank Road, Ottawa, K2H 6L3
FAX COMPLETED FORM TO: 613-596-8798 or 613-596-8726

Employee Wellness
Healthy Together

OTTAWA-CARLETON DISTRICT SCHOOL BOARD – ABILITIES FORM (2 pages)

2B: COGNITIVE (*please complete all that is applicable*)			
Attention and Concentration: ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Following Directions:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Decision- Making/Supervision:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Multi-Tasking:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:
Ability to Organize: ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Memory:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Social Interaction:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Communication:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:

Please identify the assessment tool(s) used to determine the above abilities *(Examples: Lifting tests, grip strength tests, Anxiety Inventories, Self-Reporting, etc.*

Additional comments on **Limitations (not able to do) and/or Restrictions (should/must not do) for all medical conditions**:

3: Health Care Professional to complete.

From the date of this assessment, the above will apply for approximately:	Have you discussed return to work with your patient?
☐ 6-10 days ☐ 11- 15 days ☐ 16- 25 days ☐ 26 + days	☐ Yes ☐ No
Recommendations for work hours and start date (if applicable):	Start Date: **dd** **mm** **yyyy**
☐ Regular full time hours ☐ Modified hours ☐ Graduated hours	

Is patient on an active treatment plan?: ☐ Yes ☐ No

Has a referral to another Health Care Professional been made?
☐ Yes (optional - please specify): _____ ☐ No

If a referral has been made, will you continue to be the patient's primary Health Care Provider? ☐ Yes ☐ No

4: Recommended date of next appointment to review Abilities and/or Restrictions: dd mm yyyy

Completing Health Care Professional Name:
(Please Print) _____

Date: _____

Telephone Number: _____

Fax Number: _____

Signature: _____

OSSTF – Central Agreement - 2015

Employee Wellness
Working Together

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