Print Form

OTTAWA-CARLETON DISTRICT SCHOOL BOARD

Workers Accident/Incident/Occupational Illness Report

This form must be completed in its entirety and FAXED to
EMPLOYEE WELLNESS & DISABILITY MANAGEMENT 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 of Occupational Illness

Date of incident:	Time of Injury: ☐ am ☐ pm

OR

Did condition develop over time? ☐ yes ☐ no	
Hours worked on day of injury:	Regular working hours:
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: (i.e. Gym, Classroom, yard, etc)	If no, Accident location:
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	☐ Ears(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☐ R☐	Other	L☐ R☐

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:		
1.Name	Occupation	Phone - -
2.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 (wither 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: