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: _____