Hastings and Prince Edward District School Board

FORM 421-1	
Adopted	June 10, 2010
Last Revised	October 2012
Review Date	October 2013 Annual Review

EMPLOYEE ACCIDENT/VIOLENT INCIDENT REPORT

CHECK ONE ❑ ACCIDENT ❑ VIOLENT INCIDENT

INSTRUCTIONS:

- ➔ Report the accident/violent incident immediately to your Principal/Supervisor
- ➔ Print out this form and complete all sections and sign and date it
- ➔ Ensure your Principal/Supervisor or designate signs the bottom of the form
- ➔ **SEND THE ACCIDENT/VIOLENT INCIDENT REPORT TO HUMAN RESOURCES SUPPORT SERVICES IMMEDIATELY FOLLOWING THE ACCIDENT/VIOLENT INCIDENT (within 24 hours)**
  ATTENTION: HUMAN RESOURCES COORDINATOR AND SAFE WORKPLACE COORDINATOR
  FAX: 613-966-1397 OR EMAIL: human.resources@hpedsb.on.ca

EMPLOYEE INFORMATION

EMPLOYEE NAME: _____ **HOME PHONE NUMBER:** _____

WORK LOCATION: _____ **DATE OF BIRTH:** _____

ACCIDENT LOCATION: _____ **JOB TITLE/POSITION:** _____
(classroom, hall, parking lot, etc.)

WORKING HOURS: FROM: _____ **TO:** _____ **DAYS WORKED PER WEEK:** _____

ACCIDENT/VIOLENT INCIDENT DATES AND DETAILS Please ☒ all that apply):

Date_____ **Time**_____ ❑ AM ❑PM
Date & Time Reported: **Date**_____ **Time**_____ ❑ AM ❑PM

Reported to: (Name and Position) _____

1. WAS ACCIDENT/VIOLENT INCIDENT (Please ☒ all that apply):

❑ Sudden Specific Event/Occurrence ❑ Gradually Occurring Over Time ❑ Occupational Disease
❑ Verbal (i.e., threat) ❑ Physical

2. TYPE OF ACCIDENT/VIOLENT INCIDENT (Please ☒ all that apply):

❑ Struck/Caught ❑ Fall ❑ Slip/Trip ❑ Overexertion ❑ Harmful Substance/Environment
❑ Motor Vehicle Accident ❑ Repetition ❑ Assault ❑ Fire/Explosion
❑ Other_____

3. AREA OF INJURY (BODY PART) (Please ☒ all that apply):

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

IF INJURY OCCURRED, CONTINUE WITH SECTION 4, IF NO INJURY HAS OCCURRED GO TO SECTION 5.

4. PLEASE INDICATE LOCATION OF INJURY AND LEFT OR RIGHT: ☒

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 ❑		

5. DESCRIBE what happened to cause accident/violent incident and what you were doing at the time.
For accidents: provide details related to equipment or conditions that may have been involved.
For violent incidents: describe the nature of the incident (physical/verbal/weapons/etc.) and the context.

_____

_____

(if additional space is required please use a blank sheet and submit with this document)(additional sheet attached ❑ Yes)

LOCATION: On Employer's premises ❑ Yes ❑ No Specify where (classroom, hall, parking lot, gym, etc.) _____

REPORT ANY WITNESSES: _____ _____

6. Was any individual not working for the HPEDSB partially or totally responsible for this accident/violent incident?
❑ Yes ❑ No
If **yes**, provide name _____

Are you aware of any prior similar/related problem, injury or condition? ❑ Yes ❑ No

If **yes**, please explain _____

Do you have any prior related WSIB/WCB claims? ❑No ❑ Yes - in Ontario ❑ Yes - outside Ontario

When did you first have problems with this injury/condition? _____
_____

If you did not report this to your employer right away, please tell us why: _____
_____

HEALTH CARE

Did you receive health care for this accident/violent incident? ❑ Yes ❑ No
If **yes**, when: _____

When did the HPEDSB learn that you received health care? _____

Where were you treated for this accident/violent incident? (☒ all that apply)
❑ On-site health care ❑ Ambulance ❑ Emergency Dept. ❑ Admitted to Hospital ❑ Clinic
❑Health Professional Office (Doctor/Dentist/Chiropractor/Physiotherapist)

Name, address and phone number of health professional who treated you (if known)_____
_____

Were you prescribed medications/drugs? ❑ Yes ❑ No
Were you referred for any other treatment or tests? ❑Yes ❑ No
Did you talk to your health care professional about returning to modified/regular work? ❑Yes ❑ No

LOST TIME – NO LOST TIME

Please choose ONE - **After day of accident/violent incident, you:**
❑ Returned to **regular job** and **DID NOT** lose any time and/or earnings**
❑ Returned to **modified job** and **DID NOT** lose any time and/or earnings
❑ **Lost** time and/or earnings - complete below

** If you lost time from work or sought health care regarding this accident/violent incident after filing this report, you must notify your principal/supervisor and the Human Resources Coordinator/Safe Workplace Coordinator immediately.

INVOLVEMENT OF OTHER ORGANIZATIONS

Identify any other organizations involved (Police, Employee Assistance Program, etc.): _____

EMPLOYEE DECLARATIONS AND SIGNATURE

By signing below you declare all the information provided on this report is true.
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 offense to deliberately make false statements to the Workplace Safety and Insurance Board.

EMPLOYEE'S Signature _____ Date: _____

SUPERVISOR/PRINCIPAL Signature _____ Date: _____

SUPERVISOR/PRINCIPAL INSTRUCTIONS

Accident: Complete **Form 421-2: Supervisor's Accident/Violent Incident Investigation Report** **IF** employee accident results in lost time, health care or modified work.

Violent Incident: Complete **Form 421-2: Supervisor's Accident/Violent Incident Investigation Report** for **ALL** violent incidents involving employees.

Supervisor/Principal additional information or comments: _____
(if additional space is required please use a blank sheet and submit with this document)(additional sheet attached ❑ Yes)