Form 15

EMPLOYEE'S REPORT OF INJURY/ILLNESS

VAUGHAN

NOTE: i) ALL ACCIDENTS MUST BE REPORTED TO YOUR SUPERVISOR IMMEDIATELY
ii) THIS PERSONAL INJURY REPORT IS TO BE COMPLETED BY THE INJURED EMPLOYEE (OR DESIGNATE) AS SOON AS POSSIBLE FOLLOWING INJURY:

WORKER INDENTIFICATION:

WORKER'S NAME:	POSITION:
DEPARTMENT:	SUPERVISOR:
SUPERVISOR'S TEL.# or EXTENSION:	DATE OF BIRTH OF INJURED EMPLOYEE: DAY _____MONTH _____ YEAR _____

DETAILS OF ACCIDENTAL INJURY OR ILLNESS:

DATE OF INJURY/ILLNESS/OCCURRANCE: TIME: (AM/PM)	TO WHOM DID YOU REPORT THE ACCIDENT /ILLNESS (NAME):
TREATMENT: FIRST AID ONLY: YES □ NO □ MEDICAL AID: YES □ NO □ Medical aid is defined as seeking medical treatment by a health practioner (e.g. walk in clinic, family doctor, hospital, etc…)	TYPE OF FIRST AID PROVIDED: FIRST AIDER'S NAME: DOCTOR: ADDRESS:
WHEN DID YOU REPORT THE ACCIDENT/ILLNESS: DATE): _____ TIME: _____ (AM/PM)	IF THERE WAS A DELAY IN REPORTING, EXPLAIN WHY:

DESCRIBE THE DETAILS OF WHAT HAPPENED TO CAUSE INJURY/ILLNESS:

DESCRIBE THE SIZE, WEIGHT AND TYPE OF EQUIPMENT OR MATERIALS INVOLVED:

DESCRIBE THE INJURED PART OF THE BODY INVOLVED. PLEASE SPECIFY LEFT OR RIGHT SIDE:

HAVE YOU EVER HAD ANY PREVIOUS SIMILAR INJURY/ILLNESS? YES □ NO □
IF YES, PLEASE PROVIDE DATE AND DETAILS:

WHERE DID THE INJURY/ILLNESS OCCUR? (ADDRESS/LOCATION):

IN YOUR OPINION, WHAT CONDITIONS CONTRIBUTED OR CAUSED THE ACCIDENT?

PLEASE PROVIDE COMMENTS OR RECOMMENDATIONS FOR THE PREVENTION OF A RECURRENCE:

"WITNESS STATEMENT" FORM 11 MUST BE COMPLETED BY ANY INDIVIDUAL(S) WHO WITNESSED THE ACCIDENT/ILLNESS OR PROVIDED YOU WITH ASSISTANCE.

Should my reported work-related injury or disease require medical attention or sustain lost time, by signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997. I consent to the collection of all information relating to this claim by the Board. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the Functional Abilities Form for Timely Return to Work".

Signature: Date: Telephone Number: ( )

Distribution: Health and Safety - (Original), Immediate Supervisor/Foreperson - (Copy), Injured Person - (Copy)

REV: 02JUN04