APPENDIX A-2 (AP 5-02)

DISTRICT SCHOOL BOARD OF NIAGARA

EMPLOYEE ACCIDENT REPORT

INSTRUCTIONS TO INJURED WORKER:

- ☐ Complete form and sign & date below.
- ☐ Make sure your principal/supervisor completes the Principal/Supervisor Incident Investigation Report.
- ☐ **FAX TO: WSIB Specialist, Human Resources, within 24 hours of the accident - 905-641-9223**
- ☐ ***Contact principal/supervisor to discuss return to modified or regular duties.***

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

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

ACCIDENT LOCATION: _____ **JOB TITLE/POSITION:** _____

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

Date & Time of Accident/Illness: **Date:** _____ **Time:** _____

Date & Time Reported: **Date:** _____ **Time:** _____

Reported to: (Name and Position) _____

TYPE OF ACCIDENT/ILLNESS (Please check all that apply):

- ○ Struck/Caught
- ○ Overexertion
- ○ Repetition
- ○ Other _____
- ○ Fall
- ○ Harmful Substances/Environment
- ○ Assault
- ○ Slip/Trip
- ○ Motor Vehicle Accident
- ○ Fire/Explosion

WAS ACCIDENT/ILLNESS:

- ○ Sudden Specific Event/Occurrence
- ○ Occupational Disease
- ○ Gradually Occurring Over time
- ○ Fatality

AREA OF INJURY (BODY PART) (Please check all that apply):

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

PLEASE INDICATE LEFT OR RIGHT:

Shoulder	○ Left	○ Right	Arm	○ Left	○ Right	Elbow	○ Left	○ Right
Forearm	○ Left	○ Right	Wrist	○ Left	○ Right	Hand	○ Left	○ Right
Finger(s)	○ Left	○ Right	Hip	○ Left	○ Right	Thigh	○ Left	○ Right
Knee	○ Left	○Right	Lower Leg	○ Left	○ Right	Ankle	○ Left	○ Right
Foot	○ Left	○ Right	Toe(s)	○ Left	○ Right			

EMPLOYEE ACCIDENT/INCIDENT REPORT

DESCRIBE what happened to cause accident/illness, what the worker was doing at the time, what the injury is and any details of equipment, materials, environment conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have been involved **OR** a condition that occurred gradually over time:

WHAT HAPPENED: _____

WHAT WAS WORKER DOING: _____

_____

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WHAT WAS THE INJURY/ILLNESS (strain/cut/etc.): _____

EQUIPMENT USED/ENVIRONMENT CONDITIONS: _____

_____

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

WITNESSES: _____ _____

Was any individual not working for DSBN partially or totally responsible for this accident/illness? ○ 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: _____

_____

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HEALTH CARE:

Did you receive health care for this injury? ○ Yes ○ No When: _____

When did DSBN learn that you received health care? _____

Where were you treated for this injury? (Check all that apply)

○ On-Site Health Care ○ Ambulance ○ Emergency Dept. ○ Admitted to Hospital ○ Clinic

○ Health Professional Office (Doctor/Dentist/Chiropractor/Physiotherapist)

Name, address, phone number and fax number of health professional (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/awareness of illness, did you:**

○ Return to **regular job** and **NOT** lose any time and/or earnings
○ Return to **modified job** and **NOT** lose any time and/or earnings
○ **Lose** time and/or earnings - complete below

First day of lost time _____ Date back to work _____ Regular/Modified?

It is an offense to deliberately make false statements to the Workplace Safety and Insurance Board.

I declare that all of the information provided on pages 1 and 2 is true.

_____ _____

EMPLOYEE'S SIGNATURE **DATE**

PLEASE COMPLETE & FAX WITHIN 24 HOURS OF INCIDENT TO 905-641-9223