APPENDIX D

WORKPLACE INJURY FORM

Employee/Supervisor Incident Report & Investigation Report
For Workplace Injuries/Illnesses and Violent Incidents

INSTRUCTIONS FOR COMPLETION

STEP 1: DETERMINE IF IT IS A CRITICAL INJURY

Critical Injury – Defined (R.R.O. 1990, Reg. 834, S.1, and clarification issued 2017)

- Places life in jeopardy,
- Produces unconsciousness (even momentary),
- Results in substantial loss of blood (based on victim's physical size),
- Involves the fracture of a leg, arm, hand or foot but not a finger or toe (the fracture of a wrist, hand, ankle or foot does constitute a critical injury, and the fracture of more than one finger or toes does constitute a critical injury),
- Involves the amputation of a leg, arm, hand or foot but not a finger or toe (the amputation of more than one finger or more than one toe constitutes a critical injury),
- Consists of burns to a major portion of the body, or
- Causes the loss of sight in an eye (loss of sight can be temporary from involuntary closing due to entry of substances or objects)

*** If any of the above has occurred/are present it is a Critical Injury – Proceed to Step 2**
If you are unsure, err on the side of caution and treat it as a critical injury (proceed to Step 2)
If it is not a critical injury, proceed to Step 3

STEP 2: CALL MINISTRY OF LABOUR TO MAKE A REPORT

Ministry of Labour Health & Safety Contact Centre: 1-877-202-0008 (TTY: 1-855-653-9260)

- Call any time to report critical injuries, fatalities or work refusals
- Call 8:30 a.m. – 5:00 p.m., Monday-Friday, for general inquiries
- **In an emergency, always call 911 immediately**
- **Written documentation must be submitted within 48 hours of the occurrence**

STEP 3: CONTACT YOUR SUPERINTENDENT AND THE HEALTH & SAFETY COORDINATOR

Health & Safety Coordinator: John Bell (John.Bell@dsb1.ca)
• 705-630-7702 (office) • 705-266-0125 (cell) • 705-264-7034 (fax)

STEP 4: INVESTIGATE, COMPLETE DOCUMENTATION AND SUBMIT (within 48 hours)

- **To Ministry of Labour:**
  - to inspector that was assigned to the occurrence after calling it in;
  - to the regional office at timminshealth&safety@ontario.ca; **OR**
  - complete the online form at https://forms.mgcs.gov.on.ca/en/dataset/on00276
- **To Health & Safety Coordinator (John.Bell@dsb1.ca)**
- **To Human Resources (HumanResources@dsb1.ca)**

If the employee is medically unable to complete the form, the supervisor should complete the sections they are aware of and submit to HR. The employee can update the information at a later date.

STEP 5: ADVISE AND DEBRIEF WITH HEALTH & SAFETY COMMITTEE AND REP.

If seeing a medical professional (ER, physician, physiotherapist or chiropractor), please take the **FAF FORM** (found in Docushare: Forms >> Human Resources Forms >> Health & Safety/WSIB Forms >> Workplace Injury or Illness Forms) to your Health Care professional for completion.

Ensure the Principal/Supervisor completes the Principal/Supervisor Investigation Report page.

NOTE: Your Principal/Supervisor has modified work available immediately if warranted by medical restrictions. Please speak to your Principal/Supervisor about this PRIOR to lost time occurring

CRITICAL INJURY REPORT FORM

Name of Employer:	**Address of Employer:**	**Phone Number of Employer:**
Name of Person Critically Injured:	**Address of Person Critically Injured:**	**Phone Number of Person Critically Injured:**
Time of the Occurrence:	**Place of the Occurrence:**	**Employee/Non-Employee:**
Description of the occurrence and bodily injury sustained:		
Description of machinery or equipment involved, if any:		
Names, addresses and phone numbers of all witnesses to the occurrence:		
Name, address and phone number of the physician, if any, by whom the person was or is being attended:		
Steps taken to prevent a recurrence:		

PART ONE – REPORT OF INCIDENT DETAILS

SECTION 1 – WORKER (PRINCIPAL/SUPERVISOR MAY COMPLETE IF EMPLOYEE IS NOT ABLE TO WITHIN THE TIMELINES)

Employee Name: _____ **Work Location:** _____

Employee Number: _____ **Job Title/Position:** _____

 # Days Worked per Week _____

Working Hours: **From:** _____ **To:** _____

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

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

Reported to: (Name and Position) _____

SECTION 2 – WORKER (PRINCIPAL/SUPERVISOR MAY COMPLETE IF EMPLOYEE IS NOT ABLE TO WITHIN THE TIMELINES)

LOST TIME – NO LOST TIME (the date of the accident/incident does not count as lost time)

Please choose ONE – **After the day of the accident/awareness of illness, did you:**

- ○ Return to **regular job** and **NOT** lose any time and/or earnings, **OR**
- ○ Return to **modified job** and **NOT** lose any time and/or earnings, **OR**
- ○ **Lose** time and/or earnings (after the initial day of injury) – if yes, complete the section below:

First day of lost time: _____

Date Back to Work: _____

Did you return to: ○ Regular work **OR** ○ Modified duties?

SECTION 3 – WORKER (PRINCIPAL/SUPERVISOR MAY COMPLETE IF EMPLOYEE IS NOT ABLE TO WITHIN THE TIMELINES)

HEALTH CARE

Did you receive first aid at your work location for this injury? ○ Yes ○ No

If yes, what type? _____

Did you receive health care for this injury outside of your work location? ○ Yes ○ No

If yes, please indicate when: _____

When did you notify the School Board that you received health care? _____

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

○ On location first aid only ○ Ambulance ○ Emergency Dept. ○ Admitted to Hospital

○ Clinic ○ Health Professional Office (Doctor, Dentist, Chiropractor, Physiotherapist)

Name, Address and Phone Number of Health Professional:

_____

_____

Were you prescribed medication/drugs? ○ Yes ○ No

Were you referred for any other treatment or tests? ○ Yes ○ No

Did you give your health care professional the FAF form? ○ Yes ○ No

Did you advise them that your employer has modified work available immediately? ○ Yes ○ No

Did you talk to your health care professional about returning to modified/regular work? ○ Yes ○ No

What restrictions (if any) do you have for return to work as per the medical professional indication?

Was Personal Protective Equipment available to you at your work location? ○ Yes ○ No
(i.e., safety footwear, goggles, Kevlar protection, etc.)

If Yes:

What type? _____

Were you wearing the Personal Protective Equipment? _____

If No:

Indicate the reason: _____

***NOTE: Should you seek medical attention and/or lose time from work after this report has been submitted due to your injury, you MUST notify your Principal/Supervisor AND Human Resources.**

SECTION 4 – WORKER (PRINCIPAL/SUPERVISOR MAY COMPLETE IF EMPLOYEE IS NOT ABLE TO WITHIN THE TIMELINES)

DESCRIBE what happened to cause the accident/illness/incident and what you were doing at the time. Please indicate what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have been involved. If your condition developed over time, please explain how it progressed.

SECTION 5 – WORKER (PRINCIPAL/SUPERVISOR MAY COMPLETE IF EMPLOYEE IS NOT ABLE TO WITHIN THE TIMELINES)

WAS THIS A VIOLENT INCIDENT? ○ Yes ○ No **(If Yes, complete all sections below)**

Assailant(s): ○ Student (IPRC) ○ Student (no IPRC) ○ Student's Parent ○ Visitor
○ Co-worker ○ Other: _____

Nature of Incident: (Check all that apply)

VERBAL: ○ Abuse ○ Threat

EMOTIONAL: ○ Symptomatic Stress

PHYSICAL: ○ Bite ○ Punch ○ Kick ○ Scratch ○ Pinch ○ Spit ○ Slap
○ Other: _____

Weapon(s) Involved? ○ Yes ○ No
If Yes, please specify: _____

Repeat incident involving the same assailant(s)? ○ Yes ○ No

Agencies Involved:

○ Ambulance

○ Police Officer: _____
Badge #: _____

○ Doctor ○ CAS/CCAS ○ Union

Other Information:

SECTION 6 – WORKER (PRINCIPAL/SUPERVISOR MAY COMPLETE IF EMPLOYEE IS NOT ABLE TO WITHIN THE TIMELINES)

WITNESSES (Name and Occupation) ○ Yes ○ No

If Yes, indicate their names and occupations below:

_____

_____

_____

Was any individual not working for the School Board partially or totally responsible for or involved in this accident/illness/incident other than a student of the Board? ○ Yes ○ No

If Yes, please provide names, phone numbers and names of the companies they work for:

_____

_____

SECTION 7 – WORKER (PRINCIPAL/SUPERVISOR MAY COMPLETE IF EMPLOYEE IS NOT ABLE TO WITHIN THE TIMELINES)

WHERE INJURY OCCURRED:

○ 740 - Outdoor walkways ○ 742 - Classroom ○ 746 - Hallway

○ 747 - Indoor foyer/entrance/exit ○ 754 - Office ○ 756 - Parking lot

○ 757 - Playground ○ 760 - Stairwell ○ 768 - Gymnasium

○ 776 - Library ○ Other: _____

AREA OF INJURY (Body Part)

Please check all that apply:

○ 708 - Head ○ 731 - Face ○ 701 - Eye(s)

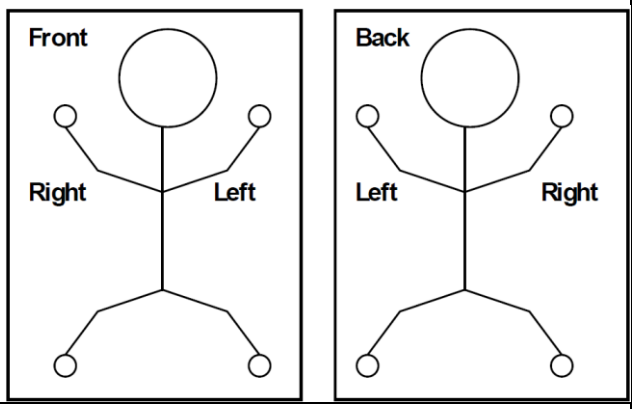
○ 703 - Ear(s) ○ 704 - Teeth ○ 709 - Neck

○ 714 - Chest ○ 721 - Upper Back ○ 728 - Hip

○ 715 - Abdomen ○ 723 - Lower Back

○ Other: _____

Using the diagram to the right, please circle the area(s) of injury. (This can be done in Adobe using the Comment feature, and selecting the drawing tool to write freehand.)



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	**Toes**	○ Left	○ Right

PRIOR CONDITIONS

Do you or have you had any prior similar/related problem, injury or condition? ○ Yes ○ No

If Yes, please explain:

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

Were these WSIB claims with DSB1 or a previous employer? _____

Dates/Claim #s or prior conditions: _____

If you did not report this to your employer right away, please indicate why:

Employee Signature: **Date:**

_____ _____

PART TWO – ACCIDENT INVESTIGATION

TO BE COMPLETED BY THE SUPERVISOR/PRINCIPAL

Please involve the Health & Safety Representative for your workplace in your investigation

SECTION 1 – SUPERVISOR/PRINCIPAL

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

If Yes, please explain:

Has modified work been discussed with the worker? _____

Has modified work been offered to the worker? (indicate date): _____

Has modified work been assigned? (indicate start date): _____

If No, please indicate why:

If Yes, please indicate the modifications/accommodations:

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

○ Struck or Contact by	○ Struck Against/Contact with	○ Fall
○ Slip/No Fall	○ Caught In, Under, On, Between	○ Possible Exposure
○ Over Exertion/Strain	○ Repetitive Body Movement	○ Traumatic Event
○ Insufficient Information	○ Violent Act Involving Student	○ Violent Act Involving Co-worker

○ Other: _____

Identify the substandard action(s) that caused or could have caused this mishap. Established by the questioning of those involved and by direct observations.

Yes	No	Code	Substandard Action	Yes	No	Code	Substandard Action
		01	Operating equipment without authority			19	Defective tools, equipment or materials
		02	Failure to warn			20	Congestion or restricted action
		03	Failure to secure/make safe			21	Inadequate warning system
		04	Operating at improper speed			22	Fire and explosion hazards
		05	Making safety devices inoperable			23	Substandard/Inadequate housekeeping
		06	Removing safety devices			24	Hazardous equipment conditions: gases, dusts, smoke, fumes, vapours
		07	Using defective/improper equipment			25	Noise exposure
		08	Using equipment improperly			26	Radiation exposure
		09	Failure to use personal protective equipment properly			27	High or low temperature exposures
		10	Improper loading			28	Inadequate or excessive illumination
		11	Improper placement			29	Inadequate ventilation
		12	Improper lifting			30	Atmosphere
		13	Improper position for task			31	Unsafe design/arrangement
		14	Horseplay/Willful misconduct			32	Weather related hazard
		15	Influence of alcohol/drugs suspected			33	Hazardous use or procedure
		16	Hazardous operation of equipment			34	Inattention
		17	Servicing equipment in operation			35	Inadequate grounds keeping
		18	Inadequate guards or barriers			36	Inadequate protective equipment

Identify the reasons for the existence of the substandard action and conditions selected above by marking each factor Yes or No. Established by direct observation.

Yes	No	Code	Substandard Action	Yes	No	Code	Substandard Action
		61	Inadequate physical capability			72	Inadequate engineering
		62	Lack of knowledge			74	Inadequate maintenance
		63	Lack of skill			75	Inadequate tools/equipment
		64	Stress			77	Wear and tear
		65	Failure to follow procedure			78	Abuse or vandalism
		71	Inadequate supervision				

Location of Spill: _____

Description of Spilled Material: _____

Quantity Spilled: _____ Time of Spill: _____ ○ am ○ pm

Clean-up Measures:

Please Check One:

- ○ Minor Incidents – within immediately identifiable small area, no effect on environment or humans, negligible volume release (<20 litres) that can be safely cleaned up by on-site personnel without use of special equipment or external experts.
- ○ Moderate Incidents – quantity in range of 20-100 litres and extent of materials is identifiable in a limited area, environmental effects not significant.
- ○ Major Incidents – quantity or extent of affected area is large and off property with possible significant potential for media or public controversy.

Occupation at time of injury: _____

○ Permanent ○ Temporary
○ Casual ○ Student
○ Other: _____

Name of Immediate Supervisor: _____

Name of Principal: _____

What training had been given in the safe performance of the work? (multiple selections possible)

○ Apprenticeship ○ Skill
○ Core modules ○ Specialty Modules
○ GHS ○ UMAB
○ Other: _____ ○ No Training ○ Not Applicable

Experience in occupation at the time of injury:

○ 0 - 6 months ○ 1 - 2.5 years ○ 5.5 - 10.5 years
○ 7 - 12 months ○ 2.5 - 5.5 years ○ > 10.5 years

INJURY	**PROPERTY DAMAGE OR LOST INSTRUCTION TIME**	**INCIDENT OR POTENTIAL LOSS**
○ First Aid	○ Equipment/Property Damage	○ Injury
○ Medical Aid	○ Fire	○ Equipment/Property Damage
○ Lost Time	○ Lost Instruction Time	○ Lost Instruction Time
○ Fatality	○ Environment	

Describe Loss:	Describe Potential Loss:

Location of Mishap (be specific):

Is there a written policy respecting this work? ○ Yes ○ No

Is there a written procedure for the job being performed? ○ Yes ○ No

Identify equipment/material involved (make and model, size, weight, shape, where pertinent):

Select the probability of recurrence which best identifies the loss potential if hazard(s) are not eliminated or controlled:

- ○ Death, permanent or total disability or property damage > $100,000 could occur frequently
- ○ Lost time injury or property damage > $10,000 but < $100,000 could occur frequently
- ○ Medical aid injury only or property damage > $1,000 but < $10,000 could occur frequently
- ○ First aid injury only or property damage < $1,000 could occur frequently

Principal/Supervisor's Signature **Date**

*Additional notes, pictures, etc. can be included with this report.