



REPORTING OF WORKPLACE INJURY/ILLNESS

PAGES 1 & 2 TO BE COMPLETED BY EMPLOYEE

If this is a **CRITICAL INJURY** Please call **HEALTH & SAFETY IMMEDIATELY** AT 705-734-6363 Ext 11314 & 11346

INSTRUCTIONS TO EMPLOYEE:

- Complete Pages 1 & 2, including signature and date.

Last name _____ First name _____	
Address _____	
Employee # _____	Date of birth (dd/mm/yyyy) _____
Home telephone _____ Work telephone _____ or e-mail _____	
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Casual Regular hours of work from _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. to _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Work location _____ Occupation _____	
Supervisor's name _____ Supervisor's telephone _____	

A. Injury/Illness Dates and Details																																																																																					
1. Date and hour of injury/Awareness of illness. dd mm yy Time <input type="checkbox"/> am _____ <input type="checkbox"/> pm Date and hour reported to employer dd mm yy Time <input type="checkbox"/> am _____ <input type="checkbox"/> pm	2. Who was the injury / illness reported to? (Name & Position) _____ <div style="text-align: right; margin-top: 10px;"> Telephone _____ Ext. _____ </div>																																																																																				
3. Was the injury/illness <input type="checkbox"/> Sudden Specific Event/Occurrence <input type="checkbox"/> Gradually Occurring Over Time <input type="checkbox"/> Occupational Disease <input type="checkbox"/> Fatality	4. Type of injury/illness (Please check all that apply) <input type="checkbox"/> Struck/Caught <input type="checkbox"/> Fall <input type="checkbox"/> Slip/Trip <input type="checkbox"/> Overexertion <input type="checkbox"/> Exposure to Harmful Substances <input type="checkbox"/> Motor Vehicle Incident <input type="checkbox"/> Repetition <input type="checkbox"/> Assault <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Other																																																																																				
5. Area of Injury (Body Part) (Please check all that apply) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"><input type="checkbox"/> Head</td> <td style="width: 15%;"><input type="checkbox"/> Teeth</td> <td style="width: 15%;"><input type="checkbox"/> Upper back</td> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;">Left</td> <td style="width: 10%; text-align: center;">Right</td> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;">Left</td> <td style="width: 10%; text-align: center;">Right</td> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;">Left</td> <td style="width: 10%; text-align: center;">Right</td> </tr> <tr> <td><input type="checkbox"/> Face</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Lower back</td> <td></td> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Eye(s)</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Abdomen</td> <td></td> <td><input type="checkbox"/> Arm</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/> Thigh</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Ear(s)</td> <td></td> <td><input type="checkbox"/> Pelvis</td> <td></td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/> Finger(s)</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/> Knee</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/> Lower Leg</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/> Ankle</td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Foot</td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Toe</td> <td><input type="checkbox"/></td> </tr> </table>		<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Upper back		Left	Right		Left	Right		Left	Right	<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Lower back		<input type="checkbox"/> Shoulder	<input type="checkbox"/>		<input type="checkbox"/> Wrist	<input type="checkbox"/>		<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen		<input type="checkbox"/> Arm	<input type="checkbox"/>		<input type="checkbox"/> Hand	<input type="checkbox"/>		<input type="checkbox"/> Thigh	<input type="checkbox"/>	<input type="checkbox"/> Ear(s)		<input type="checkbox"/> Pelvis		<input type="checkbox"/> Elbow	<input type="checkbox"/>		<input type="checkbox"/> Finger(s)	<input type="checkbox"/>		<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/> Other _____				<input type="checkbox"/> Forearm	<input type="checkbox"/>		<input type="checkbox"/> Lower Leg	<input type="checkbox"/>		<input type="checkbox"/> Ankle	<input type="checkbox"/>											<input type="checkbox"/> Foot	<input type="checkbox"/>											<input type="checkbox"/> Toe	<input type="checkbox"/>
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6. Describe what happened to cause the injury/illness and what you were doing at the time (lifted a 50 lb. box, slipped on wet floor, repetitive movements). Include what the injury is (for example, knee pain, cut leg, irritated throat). BE AS DETAILED AS POSSIBLE.																																																																																					
7. Did the injury/illness happen on school board premises? Specify where (hallway, gymnasium, parking lot, and so forth). <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																					
8. Did the injury/illness happen outside the Province of Ontario? If Yes , where (location, city, province/state, country) <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																					



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9. Were there any witnesses or other employees involved in this injury/illness? Yes No If **Yes**, provide name(s), position(s), and work phone number(s)

10. Have you had any prior similar or related problem, injury or condition? Yes No If **Yes**, please explain

B. Health Care

1. Did you receive health care for this injury? Yes No If **Yes**, when: dd mm yy

2. When did you tell the supervisor that you received health care? dd mm yy

3. Where were you treated for this injury? **(Please check all that apply)**

On-site first aid Please provide name and phone number of first aid provider: _____

Ambulance Emergency department Admitted to hospital Health Professional office Clinic Other

Name and address of the health professional or facility that treated you:
Name: _____
Address/Phone Number: _____

C. Lost Time - No Lost Time

1. Please choose one of the following: **After the day of the injury/awareness of illness, did you:**

Return to **regular job**.

Return to **modified work**.

Lose time as follows:
Provide date you first lost time dd mm yy Date you returned to work dd mm yy regular work modified work

D. Work Schedule

What are your regular hours of work **(Complete either A or B.)**

(A.) Regular Schedule – Indicate normal work days and hours. **Example:** Monday to Friday, 40 hours

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday										
							S	M	T	W	T	F	S			
								8	8	8	8	8				

Or

(B.) Varied or Irregular Work Schedule - Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the injury/illness. **(Casual or Temporary)**

	Week 1	Week 2	Week 3	Week 4
From/To Dates (dd/mm/yy)				
Total Hours Worked				
Total Shifts Worked				

Employee Signature _____ Date _____

By accepting and submitting this form, I declare that all of the information provided on pages 1 and 2 is true. I am also authorizing any health professional who treats me to provide my employer and WSIB with information pertaining to this incident.

I Accept **I Don't Accept**

Please submit and ensure your Supervisor is aware of this incident.