WORKER'S ACCIDENT REPORT

Workplace Safety & Insurance Board Requirements:

Employers are required to maintain a record of all work related accidents, and submit accident information to the WSIB within 3 days of the injury. Employers must ensure that first aid/advice is given immediately, or if necessary provide immediate transportation to a Health Care facility.

Injured Workers are required to complete an accident report immediately and authorize their Health Care Professional to provide information on their functional abilities. **PLEASE REFER TO THE BACK FOR INSTRUCTIONS.**

All **Critical Injuries** (those producing unconsciousness, substantial loss of blood, fracture of legs or arms, amputation, major burns or serious eye injuries) **MUST BE REPORTED IMMEDIATELY** by telephone to the Employee Wellness & Disability Management office tel. #(613) 596-8250.

WORKER INFORMATION

Surname: ______________________ Given Name(s): ______________________

Home Address (street, city, postal code): ______________________

Home Phone: (_____)__________________Sex: _____M _____F Date of Birth: ______________________

Work Location(School): ______________________ Social Insurance No.: ______________________

Occupation: ______________________ Employee Number (EIN): ______________________

Immediate Supervisor: ______________________ Phone: ______________________

ACCIDENT INFORMATION (TO BE COMPLETED BY THE WORKER)

DATE and HOUR of ACCIDENT? Date ________________Hour _____________ a.m./p.m.	**Will you be seeing medical attention?** YES____________NO_________ If **YES**, have treating health professional complete Functional Abilities Report (Page 2 of Accident Report). **Name & Address of Health Professional:** ______________________
DATE and HOUR accident reported? Date ________________Hour ________________a.m./p.m. **Accident reported to?** ______________________	**NOTE: All lost time for workplace injuries/disease must be authorized by health official.** If there is lost time from work due to your accident, please state: **DATE and HOUR YOU LAST WORKED?** Date ___________Hour _______a.m./p.m.

Area of body injured: ______________________(indicate right or left side if applicable)

This injury is: _______a new injury **OR** ______a recurrence injury (Claim number/date of injury) ______________________

WHERE DID THE INJURY OCCUR? (location and room number) ______________________

Name of Witnesses:______________________

What happened to cause the injury? (Please give specific details)

Give a description of any machinery/equipment involved: (size, height, weight, etc.)

____

WORKER'S SIGNATURE: By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, for a work related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB), with information about my functional abilities for a timely return to work. I declare that all the information provided on this report is true. (It is an offense to deliberately make a false statement to the WSIB).

Signature: ______________________ **Date:** ______________________

THIS SECTION TO BE COMPLETED BY THE SUPERVISOR

NORMAL WORKING HOURS: from ___________ to _________ **HOURS WORKED ON DAY OF INJURY:** from ___________ to _________ **NORMAL WORKING DAYS**: __________Monday thru Friday __________Other(specify)___________________	**(SUPERVISOR) MADE AWARE OF THE ACCIDENT/INJURY ON:** Date ______________________ Hour ______ a.m./p.m. **IS THE WORKER LOSING TIME BEYOND THE DAY OF INJURY?** YES ________ NO ________ **NOTE: All lost time for workplace injuries/disease, must be authorized by health professional.**

Attention: If the worker seeks health care or loses time at a later date, please notify the OCDSB, Employee Wellness & Disability Management office.

Supervisor's Signature: ____ **Date:** ____________________

The personal information on this form is collected under the authority of the Workplace Safety & Insurance Act. This information will only be used to comply with the statutory reporting requirements of the Act. If you wish to review this information or require additional information concerning this collection, contact the OCDSB, WSIB Coordinator.

Instructions for Completion of Worker's Accident Report

1. The **WORKER'S ACCIDENT INFORMATION** is completed by the Injured Worker and the Supervisor and then immediately **FAXED** to the Employee Wellness & Disability Management office, fax # (613) 596-8798, fax # (613) 596-8798. Information must be received within 24 hrs. of a work related accident.

2. If Heath Care or Lost Time is required, the Injured Worker must take this Worker's Accident Report to the treating Health Care Professional for them to complete the **FUNCTIONAL ABILITIES REPORT.**
A PHOTOCOPY OF THE WORKER'S ACCIDENT REPORT MUST REMAIN AT THE WORKSITE.

3. The completed Functional Abilities Report is **FAXED** to the Employee Wellness & Disability Management office at fax # (613) 596-8798 within 2 working days.

4. If there are questions/concerns, please call the Employee Wellness & Disability Management office at (613) 596-8250.

THIS SECTION TO BE COMPLETED BY TREATING HEALTH PROFESSIONAL

FUNCTIONAL ABILITIES REPORT

WORKER'S NAME:____________________________________ has authorized the treating health professional, to provide the worker, the employer, and the Workplace Safety and Insurance Board with functional abilities information. Please indicate your opinion of the worker's medical precautions. The functional abilities information allows the workplace parties to cooperate in the worker's early and safe return to work; thereby meeting the "Return to Work" obligation of the Workplace Safety and Insurance Act. Should you have any questions or concerns, contact the Ottawa-Carleton District School Board, Employee Wellness & Disability Management office at (613) 596-8250.

Medical Precautions:

Worker is capable of returning to regular work immediately: Yes ☐ Or No ☐

Worker is capable of returning to modified duties as per recommended precautions: Yes ☐ Or No ☐

Area of body involved (State right or left side, if applicable): ______________________________

Lifting: Not at all ☐ Or Not Over ☐ Kilograms

Upper Limbs: _____ Avoid sustained activity at or above shoulder level.
_____ Avoid repetitive, sustained pulling/pushing

Back: _____ Avoid sustained bending
_____ Avoid kneeling/crouching/squatting
_____ Avoid/minimize twisting and cramped quarters

Mobility: _____ Avoid static standing
_____ Avoid sustained sitting
_____ May alternate between sitting and standing as required
_____ No climbing ladders/stairs

Other: Please specify – e.g. can not operate motorized equipment, medication restriction (specify), etc.

____

Treatment:

Does this worker require further treatment? Yes ☐ No ☐

Further treatment will be carried out by:

☐ Physician ☐ Specialist ☐ Physiotherapist ☐ Chiropractor ☐ Other ____________________

When is the worker to be reassessed? Date: ________________________

Is a complete recovery expected? Yes ☐ No ☐

Name of Health Professional: ________________________ Signature: ____________________ Date: _______________

Address: ________________________________ Phone: ____________________ Fax: _______________

***THE COMPLETED REPORT MUST BE RETURNED TO**
THE OCDSB EMPLOYEE WELLNESS & DISABILITY MANAGMENT
OFFICE WITHING 2 DAYS

NOTE TO DOCTOR: A WSIB Form 8 (Physicians First Report) needs to be submitted to WSIB.