

**Greater Essex County District School Board
EMPLOYEE INCIDENT/INJURY REPORT**

PART 1 – EMPLOYEE IDENTIFICATION

Last Name:		First Name:		D.O.B.:	
Home Address:					
Male:		Female:		Home Telephone:	Work Telephone:

PART 2 – INCIDENT INFORMATION

Site of Incident:	Room:	Occupation:
Principal/Supervisor's Name:		Principal/Supervisor's Phone No.:

PART 3 – INCIDENT DETAILS / INJURY TYPE

Description of Accident: Describe in your own words what happened; include details of equipment involved (size & weight). Where applicable, include a sketch or map of incident scene.

SYMPTOMS: Indicate all that apply & are evident at the time of the incident/injury

Bleeding		Ache or Pain		Burn		Allergic Reaction	
Bite		Bruise		Bite (skin broken)			
Swelling		Abrasion		Puncture		Itching	
Laceration		Headache		Other			

AREA OF INJURY: Indicate all that apply & are evident at the time of the incident/injury

	Yes	Left	Right	Both		Yes	Left	Right	Both		Yes	Left	Right	Both
Head					Eye					Face				
Mouth					Teeth									
Lower Arm					Upper Arm					Neck				
Shoulder					Buttocks					Hand				
Fingers					Upper Leg					Lower Leg				
Knee					Foot					Toes				
Ear					Chest					Abdomen				
Back	Upper		Lower		Mid									

Date of Incident:	Time of Incident:	a.m.		p.m.	
Date Incident Reported:	Time Incident Reported:	a.m.		p.m.	
Reported to:	Were there witnesses?	yes		no	
Name of Witness:					
Employee's usual working hours:	Did employee lose time?	yes		no	
Date Last Worked:	Hour Last Worked:	Date Returned to Work:			

INCIDENT CLASSIFICATION: To be completed by the WSIB Officer

Hazardous Situation/Incident Only	Modified Work Provided to Prevent Lost Time
First Aid	Critical Injury
Medical Aid	Property Damage
Lost Time	Reoccurrence (Provide Claim No. if Possible)

In the event of a CRITICAL Injury, IMMEDIATELY Contact

WSIB Officer Kathy Czaczkowski, RPN 255-3368 Cellular 796-1671	Health & Safety Officer Tim Lauzon 255-3332 Pager 259-1092
--	--

PART 4 – MEDICAL / FIRST AID TREATMENT

Describe First Aid Treatment at Incident Site:

If you attended for MEDICAL TREATMENT, please provide:

Name of Doctor/Facility:

Address:

Telephone Number:

Date Seen:

Date of Follow-up Appointment:

TO BE COMPLETED BY SUPERVISOR / PRINCIPAL**PART 5 – INCIDENT DETAILS**

Type of incident (e.g. aggression against staff, slip and fall) and contributing factors (e.g. excited students, wet floors)

What was the employee doing at the time of the incident?

What type of equipment was involved?

Corrections/Preventions of Further Incidents, Request for Health and Safety follow up:

Was there any person not employed by the Greater Essex County District School Board involved or responsible (partially or totally) for this incident?

yes

no

If the instance of an injury/incident, is there reason to doubt that it is work related?

yes

no

If yes, please explain.

Has the employee suffered a previous similar condition/injury?

yes

no

Please provide additional comments relevant to this accident. Use separate sheet if necessary.

Employee Signature

Date

Principal or Supervisor Signature

Date

FORWARD WITHIN 48 HOURS BY FAX: 255-3207*The Occupational Health and Safety Act requires the release of prescribed information to the Joint Health and Safety Committee(s).*