



London District Catholic School Board

Incident Report Form

INSTRUCTIONS TO PRINCIPAL/SUPERVISOR:

1. **If this is a CRITICAL INJURY** (Definition: places life in jeopardy, causes a broken arm or leg (but not finger or toe), results in substantial blood loss, produces unconsciousness, loss of sight in one or both eyes, or produces widespread burns, please secure the scene and report to the Occupational Health and Safety Officer **IMMEDIATELY at 663-2088 ext. 43413** or after hours call Damar Monitoring at 1-800-265-7562 and ask to page the On-Call Supervisor.
2. **Custodial/Maintenance Supervisor** completes this report with custodial/maintenance employees and **Principal** completes with all others.
3. Please conduct an independent investigation when completing this report. Your investigation should include an interview with the injured worker and a physical investigation of the incident site before completing this report. **PLEASE FAX to Supervisor, Employee Health & Wellness, Human Resources Services at 663-2108 within 24 hours of incident!**
4. If lost time occurs or health care is sought at a later date, please advise the **Supervisor, Employee Health & Wellness** at 663-2088 ext. 43411.

INSTRUCTIONS TO EMPLOYEE:

1. Please complete this form with your Principal/Supervisor. If your Principal/Supervisor is not available, complete as much of the form as possible and **FAX to Supervisor, Employee Health & Wellness, Human Resources Services at 663-2108 within 24 hours of the incident.** When the form is complete, fax the updated form as above.
2. If seeking health care, please ensure that the attached FUNCTIONAL ABILITIES FORM (FAF) is completed by your health professional (physician, physiotherapist, or chiropractor) where appropriate. This information will allow us to provide you with appropriate and safe modified work in a timely manner.

SECTION 1

Employee Name: _____	Employee #: _____
Work Location: _____	Job Title/Position: _____
Working Hours: From: _____	To: _____
Days Worked per Week: _____	
Date & Time of Incident/Illness: Date _____	Time: _____
Date & Time Reported: Date _____	Time: _____
Reported to: (Name and Position): _____	

ALL SECTIONS MUST BE COMPLETED

SECTION 2

You must choose **ONE** of the following: **After day of incident/awareness of illness, this employee:**

- Returned to **regular job** and has **NOT** lost any time and/or earnings **(Continue to Section 3)**
- Returned to **modified job** and has **NOT** lost any time and/or earnings **(Complete question (c) below)**
- has** lost time and/or earnings - complete below **(Complete question (a) (b) (c) (d) below)**

(a) First Day of Lost Time: _____

(b) Date Back to Work: _____

(c) Modified Duties. Please explain modifications: _____

(d) Was the worker offered Modified Duties? If not, please explain why _____

Notes:

1) In order to accommodate employees with medically supported limitations, the employee's job may be modified to accommodate a safe and timely return to work. Modified Work is available and should be offered.

2) Please contact and advise the Supervisor, Employee Health & Wellness if lost time occurs at a later date.

SECTION 3

You must choose **ONE** of the following:

Did employee receive health care for this injury? Yes No If yes, please indicate when: _____

Date that the School Board learned that the employee received health care: _____

Where was the worker treated for this injury? (Check all that apply)

- On-site first aid Ambulance Emergency Dept. Admitted to Hospital
- Clinic Health Professional Office (Doctor/Dentist/Chiropractor/Physiotherapist)

Name, Address and Phone number of health professional _____

Note: Please contact and advise the Supervisor, Employee Health & Wellness if health care sought at a later date.

SECTION 4

DESCRIPTION OF INCIDENT

Injury? (Describe): _____

Describe the injury

Will this injury require you to seek health care or on-site health care? _____

If so which one

What happened to cause injury? _____

Describe what you were doing

Condition? _____

If a condition that occurred gradually developed over time, please explain how it developed.

Explain what happened to cause Incident/illness? _____

Provide any details of equipment, materials, environmental conditions that contributed to the incident.

What were you doing at the time? _____

Additional Information: _____

ALL SECTIONS MUST BE COMPLETED

SECTION 5

TYPE OF INCIDENT/ILLNESS (PLEASE CHECK ALL THAT APPLY):

- 1 Struck Against
- 2 Struck By
- 3 Fall From Elevation
- 4 Fall on Same Level
- 5 Caught In/Under/Between
- 6 Material Handling
- 7 Over Exertion/Strain
- 8 Foreign Body in Eye
- 9 Contact with Electrical Current
- 10 Contact with Temp Ext.
- 11 Contact with Chemical
- 12 Motor Vehicle Accident
- 13 Student Action
- 14 Hand Tools
- 15 Unclassified
- 16 No Injury
- 17 Insect/Animal Bite
- 18 Assault (verbal or physical)
- 19 Communicable Disease

CAUSES:

- 1 Operating without Authority
- 2 Failure to Secure or Warn
- 3 Working at Unsafe Speed
- 4 Unsafe Equipment
- 5 Unsafe Loading, Placing, Mixing, Combining
- 6 Unsafe Position or Posture
- 7 Working on Moving or Dangerous Equipment
- 8 Distracting, Teasing, Wilful Misconduct
- 9 Failure to use Personal Protective Devices
- 10 Wheeled Equipment Operation
- 11 Equipment Not Guarded or Improperly Guarded
- 12 Inadequate Illumination
- 13 Fire, Explosion, Atmospheric Hazard
- 14 Hazardous Personal Attire
- 15 Unsafe Design or Arrangement
- 16 Hazardous Method or Procedure
- 17 Weather Related Outdoors
- 18 Weather Related Indoors
- 19 Slippery Surface
- 20 2nd Party Action
- 21 Improperly Labelled or Identified
- 22 Improper Ventilation
- 23 Participating/Demonstrating Sports
- 24 Failure to Follow Established Procedures, Rule
- 25 Inattention
- 26 Physical Condition
- 27 Inadequate Help
- 28 Musculoskeletal Disorder: rep sprain/strain injury
- 29 Other _____

WITNESSES:

Are you aware of any witness or other employee involved in this incident?

- Yes No

If **yes**, provide name, phone #, : _____

Was any individual, who does not work for the board partially or totally responsible for this incident/illness?

- Yes No

If **yes**, provide name, phone #, and employer's name: _____

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

- 32 Head (L/R)
- 35 Skull
- 37 Face
- 38 Jaw
- 39 Nose
- 40 Mouth
- 41 Teeth
- 43 Throat
- 44 Neck
- 46 Eye (L/R/Both)
- 51 Ear(L/R)
- 90 Upper Back
- 91 Mid Back
- 92 Lower Back
- 93 Coccyx/Sacrum
- 95 Chest
- 96 Abdomen
- 97 Groin(L/R)
- 99 Buttocks
- Other _____

PLEASE INDICATE LEFT OR RIGHT:

- | | | | | | |
|------------------|--|------------------|--|--------------|--|
| Shoulder | <input type="checkbox"/> Left <input type="checkbox"/> Right | Upper Arm | <input type="checkbox"/> Left <input type="checkbox"/> Right | Elbow | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| Forearm | <input type="checkbox"/> Left <input type="checkbox"/> Right | Wrist | <input type="checkbox"/> Left <input type="checkbox"/> Right | Hand | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| Finger(s) | <input type="checkbox"/> Left <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| Knee | <input type="checkbox"/> Left <input type="checkbox"/> Right | Lower Leg | <input type="checkbox"/> Left <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| Foot | <input type="checkbox"/> Left <input type="checkbox"/> Right | Toe(s) | <input type="checkbox"/> Left <input type="checkbox"/> Right | | |

WHERE INJURY OCCURRED:

- 452 Bike/Pedestrian Path
- 453 Cafeteria
- 454 Classroom
- 455 Daycare Centre
- 457 Elevator
- 458 Green Area
- 459 Hallway/Corridor
- 460 Indoor Foyer
- 461 Kitchen/Servery
- 462 Lab
- 464 Maintenance Shop
- 465 Mechanical Shop
- 466 Meeting Room
- 467 Off-Site (Non Company)
- 468 Off-Site (Company)
- 469 Office
- 470 Outside Bldg Enter/Exit
- 471 Parking Lot
- 472 Playground
- 474 Road/Highway
- 475 Sidewalk
- 476 Stairwell
- 479 Washroom
- 480 Gymnasium
- 481 Library
- Other _____

ALL SECTIONS MUST BE COMPLETED

SECTION 6

PRIOR CONDITIONS:

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

If **yes**, please explain: _____

SECTION 7

CORRECTIVE & PREVENTATIVE ACTION:

- | | |
|--|--|
| <input type="checkbox"/> 1 Re-instruction of person involved | <input type="checkbox"/> 2 Re-assignment of person |
| <input type="checkbox"/> 3 Use Safer Materials | <input type="checkbox"/> 4 Order Job Safety Analysis Done |
| <input type="checkbox"/> 5 Improved Personal Protective Equip. | <input type="checkbox"/> 6 Repair or Replacement |
| <input type="checkbox"/> 7 Installation of Guard or Safety Device | <input type="checkbox"/> 8 Actions to Improve Design/Method |
| <input type="checkbox"/> 9 Check with Manufacturer | <input type="checkbox"/> 10 Discipline of Persons involved |
| <input type="checkbox"/> 11 Workplace Inspection | <input type="checkbox"/> 12 Consult with Occupational Health & Safety |
| <input type="checkbox"/> 13 Consult with JOHSC | <input type="checkbox"/> 14 Consult with Ministry of Labour |
| <input type="checkbox"/> 15 Incident under Investigation | <input type="checkbox"/> 16 Correction of Congested Area |
| <input type="checkbox"/> 17 Inform All Department Supervision | <input type="checkbox"/> 18 Improve Housekeeping Procedure |
| <input type="checkbox"/> 19 Develop written safe working procedures | <input type="checkbox"/> 20 Ergonomic Assessment |
| <input type="checkbox"/> 21 Develop Inspection Routine | <input type="checkbox"/> 22 Provide Proper Ventilation |
| <input type="checkbox"/> Other _____ | |

Describe how the above action(s) have been (or will be) implemented to prevent a recurrence & include timelines:

HEALTH & SAFETY ACTION PLAN:

1. _____
2. _____
3. _____

OCCUPATIONAL VIOLENCE INCIDENT

Section 8

OCCUPATIONAL VIOLENCE INCIDENT: (PLEASE CHECK MARK IN ALL SECTIONS THAT APPLY):

- Student **Complete the following:**
IPRC Yes No
Grade: _____
Safe Physical Intervention used Yes No
Safe Physical Intervention Form Completed Yes No
- Parent/Guardian Visitor Co-Worker
- Other _____

NATURE OF THE OCCUPATIONAL VIOLENCE INCIDENT:

- | | |
|--|--|
| <input type="checkbox"/> 395 Verbal Threat | <input type="checkbox"/> 396 Written Threat |
| <input type="checkbox"/> 397 Harassment | <input type="checkbox"/> 398 Behaviour that creates a poisoned Work Environment. |
| <input type="checkbox"/> 399 Sexual Harassment | <input type="checkbox"/> Near Miss |
| <input type="checkbox"/> 400 Racial Harassment | <input type="checkbox"/> 159 Bite |
| <input type="checkbox"/> 381 Spit | <input type="checkbox"/> 171 Scratch |
| <input type="checkbox"/> 368 Punch/Hit/Slap | <input type="checkbox"/> 369 Kick |
| <input type="checkbox"/> 366 Pinch | <input type="checkbox"/> 365 Push/Shove |
| <input type="checkbox"/> Other _____ | |

Was a weapon involved? Yes No
If **yes**, provide the type of weapon: _____

AGENCIES INVOLVED/NOTIFIED (Please check all that apply):

- 802 Police Badge Number: _____
 803 Children's Aid Society Report Number: _____
 Union _____
 Other _____

PRIOR INCIDENTS:

Have you had any prior similar/related incidents involving occupational violence? Yes No
If **yes**, please explain: _____

Employee's Signature

Date

Principal/Supervisor's Signature

Date

Please PRINT in black ink

Claim No.

A. Section A to be completed by the employer and/or worker.

Worker's Last Name	First Name	Telephone	
Address (no., street, apt.)	City/Town	Province	Postal Code

Employer's Name		
Full Address (No., Street, Apt.)		
City/Town	Prov.	Postal Code

Date of Birth (dd/mm/yyyy)
Date of Accident/Awareness of Illness (dd/mm/yyyy)
Employer Telephone
Employer Fax No.

1. Type of job at time of accident (where available, please attach description of job activities)	Area(s) of injury(ies)/illness(es)
2. Have the worker and the employer discussed Return To Work <input type="checkbox"/> yes <input type="checkbox"/> no	If no, will be discussed on dd mm yyyy
3. Employer contact name	Position

B. Worker's Signature

By signing below, I am 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 on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature	Date dd mm yyyy
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C. Health Professional's Billing Information

For billing purposes fax or mail pages 2 and 3 to the WSIB.

Health Professional's Designation
 Chiropractor Physician Physiotherapist Registered Nurse (Extended Class) Other

PROVIDER BILLING INFORMATION IN THE BOLDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

Are you registered with the WSIB? <input type="checkbox"/> yes Please enter the WSIB Provider ID. in the box provided <input type="checkbox"/> no Please call 1 - 800-569-7919 to register	WSIB Provider ID.
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Health Professional's Name (please print)	Your Invoice Number
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Address (No. Street, Apt.)	Service Code FAF
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City/Town	Province	Postal Code	Fax
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I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature	Telephone	Date dd mm yyyy
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Please PRINT in black ink

Worker's Last Name	First Name	Claim No.
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D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment dd mm yyyy	2. Please check one: <input type="checkbox"/> Patient is capable of returning to work with no restrictions. <input type="checkbox"/> Patient is capable of returning to work with restrictions. Complete sections E and F. <input type="checkbox"/> Patient is physically unable to return to work at this time. Complete section F.	
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E. Abilities and/or Restrictions

1. Please indicate Abilities that apply. Include additional details in section 3

Walking: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other (please specify)	Standing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other (please specify)	Sitting: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes - 1 hour <input type="checkbox"/> Other (please specify)	Lifting from floor to waist: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify)
Lifting from waist to shoulder: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify)	Stair climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 5 - 10 steps <input type="checkbox"/> Other (please specify)	Ladder climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> 1 - 3 steps <input type="checkbox"/> 4 - 6 steps <input type="checkbox"/> Other (please specify)	Travel to work: Ability to use public transit: <input type="checkbox"/> yes <input type="checkbox"/> no Ability to drive a car: <input type="checkbox"/> yes <input type="checkbox"/> no

2. Please indicate Restrictions that apply. Include additional details in section 3

<input type="checkbox"/> Bending/twisting repetitive movement of (please specify)	<input type="checkbox"/> Work at or above shoulder activity:	<input type="checkbox"/> Chemical exposure to:	<input type="checkbox"/> Environmental exposure to: (e.g. heat, cold, noise or scents)	<input type="checkbox"/> Limited use of hand(s): Left: <input type="checkbox"/> Gripping: <input type="checkbox"/> Pinching: <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Right: <input type="checkbox"/>
<input type="checkbox"/> Limited pushing/pulling with: <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Operating motorized equipment: (e.g. forklift)	<input type="checkbox"/> Potential side effects from medications (please specify) Do not include names of medications.	<input type="checkbox"/> Exposure to vibration: <input type="checkbox"/> Whole body <input type="checkbox"/> Hand/Arm	

3. Additional Comments on Abilities and/or Restrictions.

4. From the date of this assessment, the above will apply for approximately:
 1 - 2 days 3 - 7 days 8 - 14 days 14 + days

5. Have you discussed return to work with your patient? yes no

6. Recommendations for work hours and start date: Regular full-time hours Modified hours Graduated hours
 Start Date dd mm yyyy

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions.** dd mm yyyy

I have provided this completed Functional Abilities Form to: Worker and/or Employer