### EMPLOYEE ACCIDENT/INCIDENT REPORTING INSTRUCTIONS

#### INTENT OF THE EMPLOYEE ACCIDENT/INCIDENT REPORT FORM

The intent of the form is to provide a method of collecting data on all accident/incidents and near misses which can be utilized by the Board and the Joint Occupational Health and Safety Committees towards reducing the frequency and severity of all types of unwanted incidents in the work place.

Additionally the Board must report to the WSIB all accidents where medical attention and/or lost time are involved.

The Occupational Health and Safety Act also requires that a worker representative of the Joint Occupational Health and Safety Committee, (JOHSC), investigate any critical injury and file a report with the Ministry of Labour as well as make recommendations to the Board to prevent a similar occurrence. The information will also be reviewed by the JOHSC to identify and address potential trends in accident/incident frequency.

#### **SECTION 1**

This section is to be completed in FULL by the supervisor or designate in charge of the employee or work site. The information is basic personal information and relates the time and location of the accident.

#### **SECTION 2**

This section must be completed in FULL by the supervisor or designate in charge of the employee with information from the employee if possible. This section provides information for the accident reporting forms going to the WSIB and/or to the Ministry of Labour in the case of a Critical Injury. Some information may be filled in directly by the employee if they are able. The person in charge of the employee or designate must complete the section on corrective action. All information known that relates to the questions asked must be provided. If some information is not available immediately, complete the form with the known information and forward a copy to Human Resource Services within 24 hours of the occurrence. Obtain the missing information later and forward a copy with the updates to all parties who received the original copy.

#### **SECTION 3**

This section must be completed by the supervisor or designate in charge of the employee and signed. If the employee is unable to sign this report at the time it is generated, obtain the signature when the employee is able to sign and forward the completed signed copy as an update to all parties who received the original copy.

A copy of this report must be available on site for any Certified Worker member who may be investigating the accident/incident/near miss or Critical Injury. In the case of a Critical Injury investigation, the Ministry of Labour Inspector will request a copy of this report.

In the event of a CRITICAL INJURY, contact the York Region District School Board Health & Safety Department. 905-727-0022 or 905-727-3141, extension 2343.

# A Critical Injury is defined in Reg. 834 as:

Places life in jeopardy; produces unconsciousness; results in substantial loss of blood; involves the fracture of a leg or arm but not a finger or toe; involves the amputation of a leg, arm, hand or foot but not a finger or toe; consists of burns to a major portion of the body; or causes the loss of sight in an eye.

Following is a summary of the intent of **Sections 52 & 53** of the Occupational Health & Safety Act. Please refer to the Act for the actual wording.

Where an accident, explosion or fire causing injury, or an occupational illness occurs to a worker and the worker is disabled from performing his or her usual work or requires medical attention, the employer shall give notice to the Joint Occupational Health & Safety Committee and the respective trade Union within four days of the occurrence.

# EMPLOYEE ACCIDENT/INCIDENT REPORT

The Supervisor/Designate will ensure this form is completed in consultation with the injured employee if possible. Complete it as much as is possible and submit it within 24 hours of accident/incident. (FAX 905-841-3943) Human Resource Services WSIB Representative must be notified immediately of the occurrence @Ext. 2258. \*Critical Injury\* Notify Health & Safety Immediately\* @Ext. 2343. See instructions on first page before completing this form

## **SECTION ONE**

Name	Date of Occu	irrence	Time	Date Reported	Time
Work Location		Worker's Job Ti	itle	-1	L
Name & Job Title of Person completing report		Who was the ac	cident reporte	d to? Name & Job Title	
**************************************	******	******	*****	******	******
History of Accidental Injury/Incident.		_		Notify Health & Safety	Immediately* @Ext. 2343
Was the accident/illness/incident: Type of accident/illne	ess/incident: (P	lease check all tha	at apply)		
Sudden Specific Event/Occurrence Gradually Occurring Over Time Occupational Disease Fatality  Struck/Caught by Overexertion Repetition Fire/Explosion-B Harmful Substance	urn	Fall from Heigh Motor Vehicle I Slip/Trip/Fall-Sa Traumatic Even	ncident ame Level	Aggression/Violence –Ac Attempted Physical Harm Threatened Physical Harm Near Miss/No injury Other_	
Explain what the employee was doing when the occur	rrence happer	ned or was notic	ced. Attach	page if more space need	led.
Identify the type of equipment, it's size & weight or n involved). Attach additional sheet if required.	naterial invol	ved (specify too	ls, equipme	ent, machinery, chemica	ls or material
Indicate all parts of the body affected. If other, provided the provid	Light   Left   Ha	· 🗀 🗆 🗀	eft R Knee Lower Leg Ankle Foot Toe(s)	Head Injury Top Back Right side Left side Front	Teeth Nose Mouth
Where did the accident/incident occur?					
What conditions contributed to the accident/incident	? Attach add	itional informa	tion if requi	ired.	
The conditions contributed to the activen/medicine	. much add	ivional mitorina	aon n 10qu		
		0.4			
Names of any eyewitnesses or others having knowled	ge or history (	of the occurrent Print	ce as report	ed by worker.	

YORK REGION DIST.	RICT SCHOOL BOARD
Description of First Aid treatment given or medical treatmen	t sought.
None required Refused Medical attention Time leaving First Aid only Other	g work due to accident
Describe First Aid treatment given:	If Medical attention sought- Name and address of Hospital, Clinic or Doctor:
Name of First Aid Provider:	
**************************************	
to <u>prevent a recurrence</u> . Through investigation, facts and circ to the recommendation of the <u>corrective measures</u> needed. T <u>information</u> with staff will reduce the severity and frequency reduce the number of incidents in which our students are in corrective.	rvisor/principal investigate an accident or incident and take steps cumstances that caused the event are identified. These insights lead the implementation of these measures along with the sharing of of future injuries and, where the injury is caused by a student, crisis.  leted. If action(s) are not yet taken but will be, check planned box.
General actions: Provide details below if needed  Action(s) taken: Action date Planne  Accident area secured during investigation Temporary correction of unsafe condition Area/equipment taken out of service until repaired Equipment repair or replacement Provide/improve Personal Protective Equipment Inform all department staff of occurrence Check with supplier/manufacturer of equipment Correction of congested area Improve housekeeping Ergonomic assessment Review safety requirements for job Reassignment of person involved A plan for Worker safety Action to improve procedures Review instructions provided to staff involved Actions taken to improve design  Other actions taken:	School response to violent incident involving student
	plemented to prevent a recurrence and include timeline(s).  Persons contacted Timeline(s)
ACHOR(S)	CISOES CONTACTOR

Distribution: Human Resource Services by Fax to #905-841-3943; Original copy- Site; Photocopy-Employee Form P540-02 (Revised November 2011)

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YOR	K REGION DIS	TRICT SCHOOL BOARD		
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upervisor's Signature	signature	Date completed		
apervisor s Digitatare	Employee s	signature		Bate completed
nvestigated by JOHSC Certified Representative	Date	Report Submitted to:		Date
vestigated by JOHSC Certified Representative	Date	Report Submitted to.	Date	
dditional information attached as part of repor	t/investigatio	n. Number of pages in attachment:		
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