

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. Employee Services WSIB Representative must be notified immediately of the occurrence. Ext. 2258 *Critical Injury* Notify Health & Safety Immediately* Ext. 2343

SEE PAGE 2 FOR FURTHER INFORMATION

Name	Date of Occurrence	Time	Date Reported	Time
Work Location		Worker's Job Title		
Name & Title of Person completing report		Person reporting occurrence to Employee Services		

History of Accidental Injury/Incident.

Was the accident/illness:

- ☐ Sudden Specific Event/Occurrence
☐ Gradually Occurring Over Time
☐ Occupational Disease
☐ Fatality

Type of accident/illness: (Please check all that apply)

- ☐ Struck/Caught
☐ Overexertion
☐ Repetition
☐ Fire/Explosion

- ☐ Fall
☐ Harmful Substances/Environmental
☐ Slip/Trip
☐ Other _____

☐ Motor Vehicle Incident

☐ *Critical Injury* Notify Health & Safety Immediately*

Explain what the employee was doing when the occurrence happened or was noticed.

Identify the size, weight and type of equipment or material involved (specify tools, equipment, machinery, chemicals or material involved). Attach additional sheet if required.

Indicate all parts of the body affected. If other, provide details.

- | | | | | | | | | | | |
|---------------------------------|-----------------------------------|-------------------------------------|-----------------------------------|------------------------------------|------------------------------------|--------------------------------|-------------------------------|---------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Teeth | <input type="checkbox"/> Upper Back | Left | Right | 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"/> Wrist | <input type="checkbox"/> Hip | <input type="checkbox"/> Ankle | <input type="checkbox"/> Foot | <input type="checkbox"/> Toe(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Eye(s) | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Arm | <input type="checkbox"/> Hand | <input type="checkbox"/> Thigh | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ear(s) | <input type="checkbox"/> Chest | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Elbow | <input type="checkbox"/> Finger(s) | <input type="checkbox"/> Knee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Where did the accident/incident occur?

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What conditions contributed to the accident/incident? Attach additional information if required.

Details of corrective action taken to prevent a re-occurrence. Attach additional information if required.

Names of any eyewitnesses or others having knowledge or history of the occurrence as reported by worker.

Print	Print
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Description of First Aid Treatment given or Medical treatment sought.

- ☐ None required ☐ Refused ☐ Medical Attention Time leaving work due to accident _____
☐ First Aid only
☐ Other _____

- Reporting Category**
- ☐ 1 This section filled in
☐ 2 by Employee Services
☐ 3
☐ 4

Describe First Aid treatment given:	Name and address of Hospital, clinic or doctor:
Name of Provider:	

Supervisor's Signature	Employee's signature	Date completed
Investigated by JOHSC Certified Representative	Date	Report Submitted to:

Additional information attached as part of report/investigation. Number of pages in attachment: _____

Distribution: Health & Safety, Work Location, Employee, Joint Occupational Health & Safety Committee
Form P540-02 (Revised September 2006)

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 do not wait to forward the form. 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 filled in by the supervisor or designate in charge of the employee. All known information on first aid or medical aid rendered must be entered. If some information is not available immediately, complete the form with the known information and forward a copy to Employee Services within 24 hours of the occurrence. 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.