



MEMO TO: All TVDSB employees

FROM: Organizational Support Services (HR) – Health and Safety

SUBJECT: Updates to the Employee Accident Incident Report


DATE: February 2015

All incidents that have caused injury, or may have caused injury (i.e. near miss), must immediately be reported to the employee's principal/supervisor. The supervisor, with the assistance of the employee (if possible), will complete the Employee Accident Incident Report with as much detail as is available at the time of the accident. In the event that an incident leads to an injury, it is imperative that the injured employee receive immediate and appropriate emergency treatment. This form provides for the signature of the principal/supervisor as a minimum, and the employee's signature where possible. A copy of the completed report must be sent to the Disability Management Officer within 24 hours of the incident. **Fax to: DISABILITY MANAGEMENT 519-452-2606.**

At each quarterly meeting, the Site Committee will obtain and review all Employee Accident/Incident Reports while adhering to the confidentiality provisions. The Main Committees will obtain and review the Employee Accident/Incident Summary Reports and the Workplace Safety and Insurance Board Summary Reports pertaining to the Workers represented by the Main Committee, as reported by the Employer at the regularly scheduled meetings.

Any **highlighted area** is representative of an update to the Employee Accident Incident Report.

For more information regarding the Employee Accident Incident Report, please review the [Employee Accident/Incident Report Independent Procedure](#). If you have any further questions regarding any of the information please speak to your supervisor or your designated Safety Specialist.

 Double click on this symbol (or drag your cursor over this symbol) to receive more information on the highlighted change.




EMPLOYEE ACCIDENT / INCIDENT REPORT

PART 1 - EMPLOYEE IDENTIFICATION													
Last Name:			First Name:			Employee #							
Home Address:													
Social Insurance Number:				Date of Birth:		YEAR		MONTH		DAY			
Home Telephone No:				Work Telephone No:									
PART 2 - EMPLOYMENT INFORMATION													
Work Site:			Supervisor's Name:										
Occupation:			Supervisor's Phone No:										
Date of Hire:			Regular Hours of Work:		From:				To:				
PART 3 - INCIDENT DETAILS													
Date of Incident:			Time of Occurrence:			____ : ____		AM		PM			
Date Reported:			Time Reported:			____ : ____		AM		PM			
Reported To:													
Any Witness(es):			Yes		No								
			If yes, Name:			Occupation:							
Date Last Worked:			Hour Last Worked:			____ : ____		AM		PM			
Date Returned to Work:													
INCIDENT CLASSIFICATION:													
<input type="checkbox"/> Hazardous Situation/Near Miss (NO INJURY) <input type="checkbox"/> First Aid (on-site medical treatment required) <input type="checkbox"/> Medical Aid (medical treatment required by a health professional) <input type="checkbox"/> Lost time (medical treatment required & absent) <input type="checkbox"/> Reoccurrence if previous injury <input type="checkbox"/> *(If status of this claim changes notify Supervisor and Disability Management Officer)						NOTE: IF A CRITICAL INJURY OCCURS, IMMEDIATELY NOTIFY HEALTH & SAFETY DEPARTMENT 519 452-2000 EXT 20264 **SEE REVERSE FOR DEFINITION**							
PART 4 - FIRST AID TREATMENT													
Describe First Aid Treatment if applicable:				FOR MEDICAL AID AND LOST TIME PROVIDE:									
				Name of Attending Doctor/Facility:									
				Address:									
				Telephone No:									
				Date Seen:									
PART 5 - INJURY TYPE													
SYMPTOMS Indicate all that apply				AREA OF INJURY Indicate all that apply				Yes		Left		Right	
Abrasion				1. Head									
Allergic Reaction				2. Face									
Bleeding				3. Eye(s)									
Bruising				4. Teeth									
Burn				5. Neck									
Foreign Body				6. Chest									
Fracture				7. Back Upper Lower									
Headache				8. Abdomen									
Irritation / Rash				9. Shoulder									
Laceration				10. Arm Upper Lower									
Puncture				11. Elbow									
Sprain / Strain				12. Wrist									
Swelling				13. Hand									
OTHER (PLEASE DESCRIBE)				14. Finger(s)									
				15. Hip									
				16. Leg Upper Lower									
				17. Knee									
				18. Ankle									
				19. Foot									
				20. Toes									
				21. OTHER									


Critical Injury Reporting

Critical Injury Reporting is an incident which:

- places life in jeopardy;
- produces unconsciousness;
- results in substantial loss of blood;
- involves the fracture of an arm or leg;
- involves the amputation of a leg, arm, hand or foot;
- consists of burns to a major portion of the body;
- causes the loss of sight in an eye.

is classified as critical by *Ontario Regulation 834 Under the Occupational Health and Safety Act*. These incidents require several reporting steps before the Report is prepared. 

The Scene

 If a person is critically injured or killed at a workplace, no person can alter the accident scene in any way without the permission of a Ministry of Labour Inspector.

This does not apply if it is necessary to disturb the scene in order to:

- save a life or relieve human suffering;
- maintain an essential public utility service or public transportation system; or
- prevent unnecessary damage to equipment or other property.

The Health and Safety Department must be notified immediately of any individual that is critically injured (staff, student or member of the public) by telephone 519-452-2000 extension 20264. Please call at any time of the day for contact instructions

The Safety Specialist will immediately notify the Ministry of Labour by telephone to determine whether the incident requires further investigation and whether a Ministry Representative wishes to be present.

PART 6 - INCIDENT DETAILS (PLEASE PRINT)	
Location: (State exactly where accident / Injury occurred) e.g. Hallway	
If not reported immediately give reason	
Explain what happened to cause the injury / disease	
Describe the person's activity at time of injury / disease	
Identify the equipment and materials used and the size and weight of objects being handled	
EMPLOYEE SIGNATURE:	Date:

PART 7 - TO BE COMPLETED BY PRINCIPAL / SUPERVISOR (If possible, in consultation with employee)			
TYPE of Accident (See Reverse for Coding)	CODE:		
CAUSE of Incident (See Reverse for Coding)	CODE:		
If T10 "Verbal/Aggressive Behaviours" – Does student have a safety plan in place?		Yes	No
CORRECTIONS / PREVENTION (See Reverse for Coding)	CODE:		
Was any person not employed by the Thames Valley District School Board totally or partially responsible for the Incident?	Yes	No	
If yes, explain:			
Is there reason to doubt that this is work related?	Yes	No	
If yes, explain:			
Has the employee suffered a previous similar Injury / Condition?	Yes	No	
If yes, explain:			
Additional documentation attached?	Yes	No	

PRINCIPAL/SUPERVISOR SIGNATURE:	Date:
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Fax within 24 hours to: FAX 519 452-2606 Pr/Supv: Please print name:

Original to be mailed and distributed as follows:

White Copy - Disability Management *Yellow Copy - Safety Department* **Pink Copy - Employee/Supervisor**
Human Resource Services

Thames Valley District School Board - Employee Accident / Incident Report Form

CODES FOR TYPES

No.	DESCRIPTION	No.	DESCRIPTION
T10	Verbal/Aggressive Behaviour	T06	Exposure
T01	Struck or Contact By	T07	Over Exertion / Strain
T02	Struck Against / Contact With	T08	Repetitive Body Movement
T03	Fall	T09	Traumatic Event
T04	Slip / No Fall	T11	Insufficient Information
T05	Caught In, Under, On, Between	T12	Other (Specify):

CODES FOR CAUSES

No.	DESCRIPTION	No.	DESCRIPTION
C01	Operating Without Authority	C14	Improper Ventilation
C02	Unsafe Equipment	C15	Inadequate Clearance, Workspace
C03	Unsafe Loading, Placing, Mixing, Combining, etc.	C16	Inadequate Tools or Equipment
C04	Unsafe Position or Posture	C17	Inadequate Help
C05	Distracting, Teasing, Wilful Misconduct	C18	No Hazard
C06	Failure to Use Personal Protective Devices	C19	Making Safety Devices Inoperable
C07	Inadequate Illumination	C20	Inadequate Maintenance
C08	Fire, Explosion, Atmospheric Hazard	C21	Inadequate Housekeeping
C09	Hazardous Personal Attire	C22	Failure to Follow Established Procedures, Rule
C10	Unsafe Design or Arrangement	C23	Inattention
C11	Hazardous Method or Procedure	C24	Physical Condition
C12	Outside Hazardous Condition	C25	Other (Specify):
C13	Improperly Labelled or Identified		

CODES FOR CORRECTIONS / PREVENTION

No.	DESCRIPTION	No.	DESCRIPTION
P24	Review Safety Plan	P12	Consult with Joint Health & Safety Committee
P01	Re-instruction of Person Involved	P13	Consult with Ministry of Labour
P02	Re-assignment of Person	P14	Incident Under Investigation
P03	Order Job Safety Analysis	P15	Correction of Congested Area
P04	Improved Personal Protective Equipment	P16	Inform All Department Supervision
P05	Repair or Replacement	P17	Improve Housekeeping Procedure
P06	Installation of Guard or Safety Device	P18	Develop Written Safe Working Procedures
P07	Actions to Improve Design / Method	P19	Ergonomic Assessment
P08	Check with Manufacturer	P20	Develop Inspection Form and Routine
P09	Discipline of Persons Involved	P21	Provide Proper Ventilation
P10	Workplace Inspection	P22	Other (Specify):
P11	Consult the Health & Safety Department	P23	Safe School Policy Implemented