UNIVERSITY OF TORONTO

ACCIDENT/ INCIDENT/OCCUPATIONAL DISEASE REPORT FOR EMPLOYEES (TO BE COMPLETED IN FULL BY EMPLOYEE'S SUPERVISOR)

SUBMIT WITHIN 24 HOURS TO: HEALTH & WELL-BEING PROGRAMMES & SERVICES
263 McCAUL STREET,2nd Floor OR FAX: 416-971-3052

A: INCIDENT TYPE

❍ INCIDENT-NO INJURY ❍ MINOR INJURY-NO TREATMENT ❍ FIRST AID ❍ HEALTH CARE ❍ LOST TIME
❍ CRITICAL INJURY ❍ OCCUPATIONAL DISEASE

B: EMPLOYEE INFORMATION

LAST NAME: _____ FIRST NAME: _____

PERSONNEL NUMBER: _____ SOCIAL INSURANCE NUMBER: _____

HOME ADDRESS: _____ CITY: _____

POSTAL CODE: _____ HOME TELEPHONE: (_____)_____

WORK TELEPHONE: (_____)_____ E-MAIL: _____

EMPLOYING DEPARTMENT: _____ ORGANIZATIONAL UNIT: _____

JOB TITLE: _____ DATE OF HIRE: _____

DOMINANT HAND (CIRCLE): LEFT AND/OR RIGHT DATE OF BIRTH: _____ SEX: M F

EMPLOYEE GROUP: ❍ Academic ❍ Administration (Non-Union) ❍ Union (name and local #) _____
❍ Other (specify) _____

STATUS: ❍ FULL TIME ❍ PART TIME ❍ CASUAL ❍ SESSIONAL ❍ TEMPORARY
❍ OTHER (provide details)
_____

C: REPORTING

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____AM/PM

DATE REPORTED: _____ TIME REPORTED: _____AM/PM

_____

NAME OF SUPERVISOR TO WHOM ACCIDENT WAS REPORTED: _____

TELEPHONE: _____ E-MAIL: _____

IF THERE WAS A DELAY IN REPORTING THIS ACCIDENT, LIST REASON(S):

_____

_____

IF FIRST AID WAS PROVIDED, GIVE NAME OF PROVIDER: _____

WAS MEDICAL ATTENTION SOUGHT? ❍ YES ❍ NO

IF YES, PLEASE COMPLETE THE FOLLOWING LINE:

NAME AND ADDRESS OF ATTENDING PHYSICIAN/HOSPITAL:

D: ACCIDENT/OCCUPATIONAL DISEASE DETAILS-STATE EXACTLY (attach letter if required)

1. DESCRIBE THE INJURY, PART OF BODY INVOLVED, AND SPECIFY LEFT OR RIGHT SIDE.

2. WHAT HAPPENED TO CAUSE THE INJURY?

3. EXPLAIN WHAT THE EMPLOYEE WAS DOING AND THE EFFORT INVOLVED.

4. IDENTIFY THE SIZE, WEIGHT, AND TYPE OF EQUIPMENT OR MATERIAL INVOLVED.

5. WHERE DID THE ACCIDENT OCCUR?

Street address:_____ Room number:_____

Building name: _____

6. WHAT CONDITIONS ATTRIBUTED TO THE ACCIDENT?

7. WHAT STEPS HAVE BEEN TAKEN TO PREVENT RECURRENCE?

8. NAME AND WORK ADDRESS OF ANY WITNESSES:

E: ADDITIONAL INFORMATION *complete if time was lost from work*

DATE AND HOUR LAST WORKED: _____AM/PM

NORMAL WORKING HOURS ON LAST DAY WORKED: FROM _____AM/PM TO: _____AM/PM

RATE OF PAY: ❍ HOURLY _____ ❍DAILY _____ TOTAL WEEKLY PAY HOURS: _____

SHIFT WORKER: ❍ YES ❍ NO IF YES, ENTER SHIFT PREMIUM: $_____ per hour

CIRCLE EMPLOYEE'S USUAL WORK DAYS:

Sunday: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday:

ESTIMATED TIME OFF WORK: _____ (days / shifts)

F: CLAIM INFORMATION

To your knowledge, has the worker had a previous similar injury/disease? ❍ YES ❍ NO
If yes, provide details and whether a similar injury was work related or not.

Was any individual who does not work for you totally or partially responsible for the injury/disease? ❍ YES ❍ NO
If yes, please explain.

If machinery, equipment or a motor vehicle was totally or partially responsible for the injury/disease, refer to the instructions on the reverse of the Employer's Copy and provide particulars.

Do you have any reason to doubt that the injury/disease is work-related? ❍ YES ❍ NO
If yes, please explain.

TO BE SIGNED BY DEPARTMENT HEAD OR EMPLOYEE'S SUPERVISOR

COMPLETED BY: (please print) TITLE:

_____ _____

SIGNATURE: DATE: TELEPHONE:

_____ _____ _____

WHEN TO COMPLETE THIS FORM

The Workplace Safety and Insurance Board (WSIB) requires that employers file a report within three days of learning of an occupational injury or disease that disables an employee or requires health care. Failure to do so may result in a late filing penalty being levied. Please print clearly in ink. If all of the information is not immediately available to you, please send what you have and submit further information as soon as you have it. If additional space is required, attach a separate letter. First aid only injuries are not reported to the WSIB but the WSIB requires that we keep a record of the details.

TYPES OF INJURIES

NON-INJURY
Refers to an accident in which there was no personal injury, but which has the potential for personal injury.

MINOR-INJURY
When an injury occurs but does not require treatment by a first-aider or by a health professional.

FIRST AID
When an injury occurs but the employee does not require health care, but only the treatment of a first-aider, nurse, or non-medical.

HEALTH CARE
An employee seeks medical attention from a health professional i.e. physician, chiropractor, specialist, physiotherapist, registered nurse (extended class) or dentist but does not lose any time from work beyond the accident date.

LOST TIME
When an employee does not report for work on the next scheduled shift as a result of a work related injury.

OCCUPATIONAL DISEASE OR ILLNESS
Refers to a condition that results from exposure in a workplace to a physical, chemical, or biological agent to the extent that the normal physiological mechanisms are affected and the health of the employee is impaired.

EMPLOYEE RESPONSIBILITIES

1. Promptly receive first aid.
2. Notify your supervisor immediately of any injury, including injuries which do not require medical attention or lost time.
3. Choose a doctor or other qualified practitioner (hospital, physician, chiropractor, physiotherapist, registered nurse -extended class, dentist).
4. Complete and return all report forms received from the WSIB.
5. In the case of a lost time injury, keep your supervisor updated as to your progress.

SUPERVISOR RESPONSIBILITIES

1. Ensure that first aid is received.
2. Provide transportation for the employee to a medical facility or to their home.
3. Investigate the accident and determine causes and make necessary changes.
4. Send a completed accident report to the Office of Environmental Health and Safety within 24 hours.

CRITICAL INJURY IS DEFINED AS AN INJURY OF A SERIOUS NATURE THAT:

(a) places a life in jeopardy
(b) produces unconsciousness
(c) results in substantial loss of blood
(d) involves the fracture of a leg or arm but not a finger or toe
(e) involves the amputation of a leg, arm, hand or foot, not a finger or toe
(f) consists of burns to a major part of the body
(g) causes the loss of sight in an eye

EXAMPLES OF ALTERED STATE OF CONSCIOUSNESS COULD INCLUDE NEAR DROWNING, ELECTRIC SHOCK, OR SEIZURE.

IN THE EVENT OF A CRITICAL INJURY, SUPERVISORS ARE RESPONSIBLE FOR:

1. Procuring immediate medical attention.
2. Notifying the: University of Toronto Police at: 978-2222
   Office of Environmental Health and Safety at: 978-4467
   Ministry of Labour at: 416-314-5421
   Mississauga 905-273-7800
   Scarborough 416-314-5300 or 416-314-5419
   Appropriate Joint Health and Safety Committee for that workplace
   Appropriate Union member representing the injured employee
   Health & Well-Being Programs & Services 416-978-8804
3. Ensuring the site of the accident remains undisturbed until a Ministry of Labour inspector has arrived.
4. Preparing a written report of the circumstances of the accident.