



UNIVERSITY OF TORONTO

ACCIDENT/INCIDENT/OCCUPATIONAL DISEASE REPORT FOR EMPLOYEES

RELEVANT SECTIONS MUST 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: DATE REPORTED: TIME REPORTED: 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? (location, building, room number)
6. WHAT CONDITIONS ATTRIBUTED TO THE ACCIDENT?
7. WHAT STEPS HAVE BEEN TAKEN TO PREVENT RECURRENCE?
8. NAME AND WORK ADDRESS OF ANY WITNESSES:

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

DATE AND HOUR LAST WORKED: \_\_\_\_\_

NORMAL WORKING HOURS ON LAST DAY WORKED: FROM \_\_\_\_\_ TO: \_\_\_\_\_

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)

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**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 (8:30 a.m. to 5:00 p.m.): 416-314-5421 or 1-800-991-7454
  - (Nights/Weekends/Holidays): 416-325-3000 or 1-800-268-6060
  - Appropriate Joint Health and Safety Committee for that workplace
  - Appropriate Union member representing the injured employee
  - Health & Well-Being Programmes & 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.