Complete and submit the Employee's Report of Accident/Injury (ERAI) form within 48 business hours of incident to the Disability Claim Administration Office (DCAO):

Fax to 416-393-8533

or

Scan and email to DCMsubmissions@tdsb.on.ca

General Instructions

- If you don't have computer access and are writing information – do not use light coloured ink pens or light pencil.
- Complete the form as thoroughly as possible to avoid follow-up questions from the DCAO or WSIB Representative.
- This form is meant to report workplace related incidents or illnesses that **involve the employee. It can be completed by the employee or the employee's supervisor.**
- Do not provide full name of a student – only use initials to identify students for confidentiality.
- If an employee is absent from work and/or unable to complete the ERAI, the supervisor must complete the form and contact the employee to collect information regarding the incident. Do not wait for the employee to return to work in order to complete the form.
- Prompt reporting and completion of this form is necessary to ensure TDSB meets our legal reporting obligations under the Workplace Safety & Insurance Act (WSIA) & Occupational Health & Safety Act (OHSA).

First Aid *(A minor injury was sustained that required attention by a Certified First Aider or was self-administered/monitored)*

Examples:

- Employee was struck in the head by a soccer ball during supervision duty on the playground and applied ice to the area.
- Employee slipped on wet floor and twisted their ankle; a first aider examined their ankle for signs of swelling

Health Care *(Employee sought medical attention which includes an MD, Chiropractor, Physiotherapist, Dentist, Hospital Emergency, etc.)*

Example:

- Employee cut their finger while using the paper cutter and went to the Hospital Emergency Department for stitches.
- Employee had workplace exposure to a virus and required diagnostic testing (i.e. nasal swab or x-rays)

Lost Time *(Time lost is any time **following the day of injury** – absence on the day of injury is not Lost Time)*

Example:

- Employee injured their knee after slipping and falling on ice covered blacktop in the parking lot. She was absent for scheduled shifts (2 days).

Special Notes

Classification of Incident (First Aid, Health Care, Lost Time)

- Indicate the classification of the incident (as per the definitions noted above).
- If there is a change (i.e. the report was submitted as First Aid and employee went to the doctor later), resubmit a **revised** ERAI and/or inform your Principal/VP/Manager/Supervisor immediately and they will notify the Disability Case Administration Office with an email

Signatures

- The Principal/VP/Manager/Supervisor must sign and date to acknowledge they have been notified of incident.
- The employee's signature is to indicate that they have received a copy of the report – it is not necessary to wait for this signature before submitting to the Disability Claim Administration Office.

Reminder: The accident report is only for employees. For students, parents, or volunteers, an OSBIE incident report should be completed in the school office and forwarded to the Risk Management Office at 5050 Yonge Street.

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Please print in black ink

EMPLOYEE'S REPORT OF ACCIDENT/INJURY (ERAI)

Employee Information

(Mandatory fields **– MUST COMPLETE)

Last Name: **	**First Name: ****		**Employee Number: ****
Address (number, street, apt., suite, unit): **			**Phone # (where you can be reached): ****
City/Town: **	**Province: ****	**Postal Code: ****	**Alternate/Cell Phone:**
Person Completing This Form (if other than injured worker):		**Occupation**	**School/Dept.:** / **Date (dd/mm/yy)**

Employment Information

(This section has all mandatory fields to complete)

Job Title: (if you have multiple assignments, please list all) 1.	**Work Location/School Name** (if you work at multiple locations, please list all) 1.		
2.	2.		
Learning Centre/Area:	**Regular Hours of Work:** **From:** **To:**	**Support:** ☐ Perm ☐ Acting ☐ Casual ☐ Other	**Teaching:** ☐ Perm ☐ LTO ☐ Occasional ☐ Other
Supervisor/Principal's Name & Title:	**Union/Employee Group(s):** (i.e. ETFO, Unit A/B/C/D/E, Schedule II)		

Accident/Illness Dates & Details

(This section has all mandatory fields to complete)

1.	**Date and hour of accident/awareness of illness**	**dd**	**mm**	**yy**	**Time**	**2.**	**Date and hour reported to supervisor**	**dd**	**mm**	**yy**	**Time (am/pm)**

2. Did the accident/illness happen on TDSB property or other? ☐ **Yes (TDSB Property)** ☐ **No (Other)**

Specify where it happened (classroom, shop floor, parking lot, etc.) **Location:**

3. Details of Incident: (Choose type of incident and provide details below)

☐ **Sudden onset type of injury/illness**
(State exactly the sequence of events leading to the accident/injury. What was the person doing? Describe your injury and what happened to cause it? Provide details, which include size, weights and names of any objects/equipment involved.)

☐ **Gradual onset**
(Describe when the injury first occurred and cause of injury. Explain the work that you do and if any of your regular work duties have changed. If there was delayed reporting please explain why. If applicable, provide details, which include size, weights and names of any objects/equipment involved.)

☐ **Occupational Illness / Workplace Exposure**
(Provide details on what substance/ contagion you were exposed to. Date of exposure? How long was your exposure? Please provide details on how you know you were exposed. Was there an outbreak or a confirmed case within your direct work area/ location? What type of Personal Protective Equipment were you wearing at the time of exposure? If applicable, attach any documents from the Public Health Authority to confirm you had an exposure.)

☐ **Recurrence of a prior WSIB claimed injury:** **Previous WSIB Claim #:** _____
(Provide previous injury date and previous WSIB claim number. If you are experiencing problems as a result of an original work injury, please describe how it has worsened along with any details or changes to your current condition.)

Describe details based on the box you selected above: (attach separate page if required)

(additional space provided on next page)

Describe details (continued):

4. Area of Injury (Body Part) – Please check all that apply

☐ Head
☐ Face
☐ Eye(s)
☐ Ear(s)
☐ Teeth
☐ Neck
☐ Chest
☐ Upper back
☐ Lower back
☐ Abdomen
☐ Pelvis

Left		Right
☐	Shoulder	☐
☐	Arm	☐
☐	Elbow	☐
☐	Forearm	☐

Left		Right
☐	Wrist	☐
☐	Hand	☐
☐	Finger(s)	☐

Left		Right
☐	Hip	☐
☐	Thigh	☐
☐	Knee	☐
☐	Lower Leg	☐

Left		Right
☐	Ankle	☐
☐	Foot	☐
☐	Toe(s)	☐

☐ Other: _____

Are you: ☐ **Left-Handed** ☐ **Right-Handed**

5. Condition that contributed to Injury:

☐ Overexertion
☐ Client Handling
☐ Strain/Sprain
☐ Burn
☐ Repetition
☐ Material Handling
☐ Slip/ Trip
☐ Other (please explain): _____
☐ Workplace Violence
☐ Motor Vehicle Accident
☐ Fall
☐ Struck by or Caught between something
☐ Workplace exposure causing illness
☐ Harmful Substances / Environmental

5. Have you hurt this area(s) of your body before?	☐ **Yes** ☐ **No** (**If yes, please explain below):**
6. Have you have any prior related accidents/injuries? If yes, please provide details (i.e. date, description, etc.)	

7. Was there any witness(es) who were present or saw the incident?
☐ **Yes** ☐ **No**

If yes, please provide witness(es) full name/occupation and phone #

1. _____ **Phone:** _____

2. _____ **Phone:** _____

First Aid *A minor injury was sustained that required attention by a Certified First Aider **or** was self-administered/monitored for further injury.*

Did you get first aid or care at work?	**If yes, when: (d/m/y)**	**And by whom** ☐ Certified First Aider ☐ Co-worker ☐ Self
☐ Yes ☐ No	| |	**Name:**

Describe First Aid: *(e.g. applied ice, bandage, etc.)*

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EMPLOYEE'S REPORT OF ACCIDENT/INJURY (ERAI)

Health Care Information

Mandatory fields **– MUST COMPLETE (*Employee sought medical attention which includes a Chiropractor, Physiotherapist)*

1. Did you receive health care for this injury/illness? ☐ Yes (if yes, provide details below) ☐ No

2. Where did you go for health care, for your injury, outside of work? (check all that apply)

		Facility/Hospital (Name, Address & Phone Number)	Date of Visit
☐ On-Site Health Care ☐ Clinic ☐ Emergency Dept.	☐ Ambulance ☐ Admitted to Hospital ☐ Health Professional Office (Doctor /Dentist/Chiro/PT)		| |
		Name of Health Care Professional:	dd | mm | yy

3. Did you talk to your health professional about going back to regular or modified work? ☐ Yes ☐ No **If yes, were you given any work limitations?** ☐ Yes ☐ No

4. Did you tell your supervisor you went for medical treatment? ☐ Yes ☐ No **If no, please report it right away.**

If yes, when? **dd mm yy** **and to whom?** **Name:** **Position:**

Lost Time

Mandatory fields **– MUST COMPLETE (*Time lost following the day of injury (time lost on the day of injury is not included)*

1. After the day of accident/illness: **

☐ I returned to work my **regular job** and **did not** lose any time or pay.
☐ I returned to **modified duties** and **did not** lose any time or pay.
☐ **I lost time and/or pay** (e.g. regular pay, took a sick or unpaid day)

Date you first lost time and/or pay:

dd	mm	yy

2. If you lost time, have you returned to work?** ☐ Yes ☐ No

If yes → **Date of your return to work:**

dd	mm	yy

☐ regular work ☐ modified work

If no → **Did you discuss return to work with your supervisor?** ☐ Yes ☐ No

Employee (Print Name)	Employee's Signature	Date (dd/mm/yy):
Supervisor/Principal (Print Name)	**Supervisor/Principal's Signature**	**Date (dd/mm/yy):**

Additional Information required as per the Occupational Health & Safety (OHS) Act:

- NOTE – Supervisors need to complete and submit the following report to Occupational Health and Safety Department within 4 days from the date the employer was made aware of the workplace incident.
- Under the Occupational Health and Safety Act, Supervisors have an obligation to formally investigate all incidents that result in lost time from work. For incidents that do not incur lost time, Supervisors must still review the incident to determine if any corrective actions are applicable; however, no formal investigation is required. Please use the following links to submit an online investigation for this injury.
- For any questions related to the following reports please contact the OHS office at: **416-397-3210**

If injury is not a result of violence, please complete: **Supervisors Accident/Incident Investigation Report (SAIR)**

https://tdsb.visdatec.com/SAIR/default.cfm?ilink=1

If injury is a direct result of violence, please complete: **Supervisor's Workplace Violent Incident Investigation Report (SWVIIR)**

http://tdsbweb/_site/ViewItem.asp?siteid=266&menuid=40501&pageid=33894