



EMPLOYEE'S REPORT OF ACCIDENT/INJURY

AFTER FORM IS FULLY COMPLETED, FAX IMMEDIATELY TO (416) 393-8533.

INJURED WORKER (Report this injury or accident to your Principal/Dept. Head/Team Leader/Supervisor immediately.)

PERSONAL INFORMATION		
LAST NAME:	FIRST NAME:	
DATE OF BIRTH:	SOCIAL INSURANCE #:	
ADDRESS:	CITY:	POSTAL CODE:
HOME PHONE:	WORK PHONE:	
EMPLOYMENT INFORMATION		
JOB TITLE:	SCHOOL/LOCATION:	
REGION:	SUPERVISOR'S NAME:	
REGULAR HOURS OF WORK:	SUPERVISOR'S TITLE:	
FROM:	TO:	
INJURY INFORMATION		
DATE OF INJURY:	TIME OF INJURY:	
DATE & TIME LAST WORKED (ONLY IF LOSING TIME):	RETURN DATE (IF KNOWN):	
DATE & TIME REPORTED TO PRINCIPAL/DEPT. HEAD/TEAM LEADER/SUPERVISOR:		
REGULAR SCHEDULED OVERTIME: DAYS:	HOURS: FROM	(hrs/min) TO (hrs/min)
PERSON PROVIDING INFORMATION (IF OTHER THAN INJURED WORKER)		
NAME:	OCCUPATION:	SCHOOL/DEPT:
DATE AND TIME YOU WERE MADE AWARE OF INJURY:		
WITNESS OR PERSON HAVING KNOWLEDGE OF INJURY		
NAME:	OCCUPATION:	SCHOOL/DEPT:
DESCRIPTION OF ACCIDENT (PROVIDE CLEAR, CONCISE, COMPLETE INFORMATION)		
1) DESCRIBE INJURY (Part of body affected, including left/right side, and type of injury, e.g., pain, cut, bruise):		
2) ACCIDENT LOCATION:		
3) HOW DID THE ACCIDENT OCCUR? (What were you doing? What happened? How did it happen? Problem with equipment? Size/weight/type of materials involved? Building environment? Substandard practices? People?):		
4) HAVE YOU HAD A PREVIOUS SIMILAR INJURY?		
INITIAL TREATMENT OF INJURY (INDICATE WHICH OF THE FOLLOWING APPLIES)		
<input type="checkbox"/> FIRST AID only (No medical visit)		
<input type="checkbox"/> DOCTOR* <input type="checkbox"/> HOSPITAL* <input type="checkbox"/> CHIROPRACTOR* <input type="checkbox"/> PHYSIOTHERAPIST*		
*GIVE NAME/ADDRESS/PHONE NO:		

PLEASE ATTACH A SEPARATE PAGE IF MORE SPACE IS REQUIRED.