

# Occupational Health and Safety for New Teachers

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## *What's ahead...*

- 1) Basic principles
- 2) What's wrong with this picture?
- 3) Reporting Forms
- 4) A scenario

Teachers' occupational health and safety entitlements are governed by the *Occupational Health and Safety Act*, and Regulation 851.



## *Our three basic rights are:*

- the right to **know**;
- the right to **refuse unsafe work**; and
- the right to **participate**.





# Duties of workers

28. (1) A worker *shall*,

- (a) *work in compliance with the provisions of this Act and the regulations;*
- (b) *use or wear the equipment, protective devices or clothing that the worker's employer requires to be used or worn;*
- (c) *report to his or her employer or supervisor the absence of or defect in any equipment or protective device of which the worker is aware and which may endanger himself, herself or another worker; and*
- (d) *report to his or her employer or supervisor any contravention of this Act or the regulations or the existence of any hazard of which he or she knows.*

**-The Occupational Health and Safety Act**

## Ministry of Labour, Immigration, Training and Skills Development

Helping protect workers and settle workplace disputes, supporting skilled trades, apprenticeships and employment services, attracting highly-skilled newcomers and helping people get settled in Ontario.



*Who's the boss?*

# *What's wrong with this picture?*

*A sight-seeing tour of some schools near you*

Do you see a safety issue?

Is there a fix?



Do you see a safety issue?  
Is there a fix?





Do you see a safety issue?

Is there a fix?

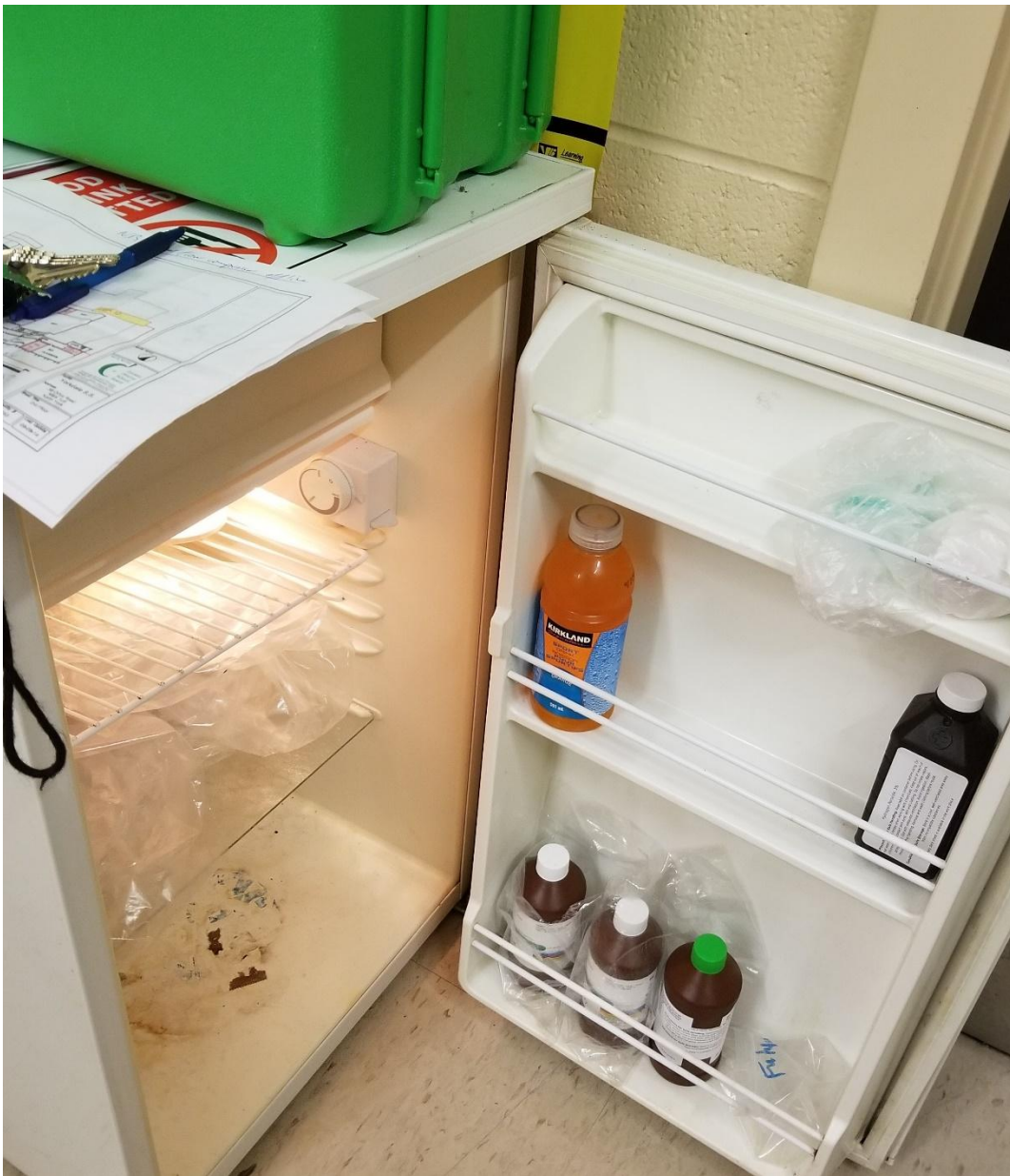


Do you see a safety issue?  
Is there a fix?





Do you see a safety issue?  
Is there a fix?



Do you see a safety issue?

Is there a fix?





Do you see a safety issue?

Is there a fix?



Do you see a safety issue?



Is there a fix?





Is there a fix?

Toronto

## Ontario needs to tackle \$16.8B school repair backlog: advocates

Minister of education says school boards need to 'do their job'



Vanessa Balintec · CBC News · Posted: May 29, 2024 2:11 PM EDT | Last Updated: May 29



Is there a fix?



- Is a **precariously employed** Occasional Teacher working in multiple schools, more at risk from Covid?
- Did schools in Toronto's more **racialized communities** have higher per capita cases of Covid and higher positivity rates?
- Were **racialized workers** in Ontario (in education and other sectors) more likely to be exposed to covid, or other workplace hazards?
- Are Ontario **women** more disproportionately impacted by workplace violence?
- Was a **manager or a boss** more likely to work from home during a pandemic?



Occupational Health and Safety is **political**,  
and is about ***social justice***.

# Reporting Forms



# On TDSBweb...



## Forms and Documents





# On TDSBweb...

Occupational Health and Safety Alerts
Electronic Workplace Inspection Process (E-WIP)
▼ <b>Forms and Documents</b>
<b>Forms</b>
Assessments
Communication
Hazardous Waste Disposal
SDS Sheets
Signage and Posters
OH&S Bulletin Board
Programs, Policies, Procedures, Protocol/Guidelines
▶ Services
▶ Trainings

## Below is a Guide to Occupational Health and Safety Reporting Forms

▶ **Employee's Report of Accident/Injury (ERAI)**

▶ **Supervisor's Accident Investigation Report (SAIR) \*Online only**

▶ **Employee's Report of a Workplace Violent Incident (ERWVI) \*Online Only**

▶ **Supervisor's Workplace Violent Incident/ Investigation Report (SWVIIR) \*Online Only**

▶ **Health and Safety Concern, Near Miss/ Incident Form \*Available Online**

▶ **Spill Incident Report**

▶ **AED/Naloxone Use Report**

# Health and Safety Concern/Near Miss Incident Form



A Concern is defined as a potential or existing hazard which presents risk to the Health or Safety of individuals in the workplace.

A Near Miss Incident is defined as an event or condition, which, under slightly different circumstances could have resulted in harm to people.

All workers shall bring to the attention of their immediate supervisor, any Occupational Health and Safety (OH&S)


## The TDSB Health and Safety Concern/Near Miss

\* Please select the type of safety request you would like to submit

☐ Concern ☐ Near miss

\* Please select the type(s) of Concern/Near Miss

\* Briefly describe the health safety hazard/near miss: 

Include details such as who (do not use staff/student names), what, and where. You are limited to 500 words. 

\* Please provide a suggestion for resolution:

## The TDSB Health and Safety Concern/Near Miss

## About &amp; Contact

[Who We Are](#)[What We Do](#)[Executive Members](#)**Health and Safety Inspectors**[Denis Da Ros](#)[Eitan Laufer](#)[Soma Srivastava](#)[Dismantling Anti-Black Racism  
and Intersectionality Officers](#)[Staff](#)

## Health and Safety Inspectors

Our Health & Safety inspectors are Denis Da Ros, Eitan Laufer and Soma Srivastava. Their duties include:

- Conducting monthly workplace inspections at Toronto District School Board sites.
- Attending monthly JH&SC, Worker Caucus, & all inspector meetings representing OSSTF TTBU interests.
- Investigating accidents, near misses, & concerns.
- Providing/assisting members with Health & Safety forms, policies, & procedures.
- Supporting & Assisting members/Executive with WSIB claims, Duty to Accommodate issues, & work refusals.



**You can find your Health and Safety Inspector by entering your school name in the search window below.**

Health and Safety Inspectors by School:

**Denis Da Ros**

*Health & Safety Inspector -  
OSSTF Toronto Teachers  
Bargaining Unit*

**Eitan Laufer**

*Health & Safety Inspector -  
OSSTF Toronto Teachers  
Bargaining Unit*

**Soma Srivastava**

*Health and Safety - OSSTF  
Toronto Teachers Bargaining  
Unit*

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](mailto: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.

Revised 2021.03.04

# The TDSB has an **accident and injury reporting form.**

## *This form may also require a WSIB claim.*

## We're here to help



Register your  
business



Report and pay  
premiums



Report an injury or  
illness



Manage your claim



Submit a  
document



Submit a health  
care invoice for  
payment



*...to file a WSIB claim.*



**A. Patient and Employer Information - (Patient to complete Section A)**

Last Name	First Name	Init.	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address (no., street, apt.)		City/Town	Prov. ON Postal Code
Telephone	Social Insurance No.	Date of Birth	Language <input type="checkbox"/> Eng. <input type="checkbox"/> Fr. <input type="checkbox"/> Other
Employer Name			

The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the Workplace Safety and Insurance Act. The Social Insurance Number may be used to identify workers and to issue income tax information statements as authorized by the Income Tax Act. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-0750.

**B. Incident Dates and Details Section**

1. How did the injury/reinjury or illness occur at work?

Occupation

Date of incident/or when did the symptoms start? dd mm yyyy

**C. Clinical Information Section - (Please check all that apply)**

**1. Area of Injury/Illness**

<input type="checkbox"/> Brain	<input type="checkbox"/> Ears	<input type="checkbox"/> Upper back	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Wrist	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Hip	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Ankle
<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Lower back	<input type="checkbox"/> Arm	<input type="checkbox"/> Hand	<input type="checkbox"/> Thigh	<input type="checkbox"/> Knee	<input type="checkbox"/> Lower Leg	<input type="checkbox"/> Foot	<input type="checkbox"/> Toes			
<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Elbow	<input type="checkbox"/> Forearm	<input type="checkbox"/> Fingers							
<input type="checkbox"/> Eyes	<input type="checkbox"/> Chest	<input type="checkbox"/> Pelvis										

Other:

**2. Description of Injury/Illness Physical Examination Findings**

☐ Pain at rest/Night Pain

**Pain Rating Scale**

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

**Exposure/Illness**

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Disc Herniation	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Repetitive Strain Injury	<input type="checkbox"/> Asthma
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Internal Joint Derangement	<input type="checkbox"/> Spinal Cord Injury	<input type="checkbox"/> Cancer
<input type="checkbox"/> Bite	<input type="checkbox"/> Fall from Height	<input type="checkbox"/> Joint Effusion	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Fumes - Inhalation
<input type="checkbox"/> Burn	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Laceration	<input type="checkbox"/> Surgical Intervention	<input type="checkbox"/> Hand-arm Vibration
<input type="checkbox"/> Contusion/Hematoma/Swelling	<input type="checkbox"/> Fracture	<input type="checkbox"/> Neurological Dysfunction	<input type="checkbox"/> Tendonitis/Tenosynovitis	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Crush Injury	<input type="checkbox"/> Hernia	<input type="checkbox"/> Psychological	<input type="checkbox"/> Range of Motion	<input type="checkbox"/> Infectious Disease
<input type="checkbox"/> Other	<input type="checkbox"/> Infection	<input type="checkbox"/> Puncture (non-needlestick)		<input type="checkbox"/> Needle Stick
				<input type="checkbox"/> Poisoning/Toxic Effects
				<input type="checkbox"/> Skin Condition

**3. Are you aware of any pre-existing or other conditions/factors that may impact recovery?** ☐ yes ☐ no

If yes, describe

**4. Diagnosis**

**D. Treatment Plan**

1. What is the treatment plan (type of treatment, duration) including prescribed medications?

2. To be completed by physicians only.

Work Injury/Illness Medications	Dose	Frequency	Duration	Work Injury/Illness Medications	Dose	Frequency	Duration
1.				3.			
2.				4.			

**3. Investigations & Referrals:**

☐ None ☐ Labs ☐ Xrays ☐ CT Scan ☐ MRI ☐ EMG ☐ Ultrasound ☐ Other

☐ PP/GP ☐ Occupational Health Centre ☐ Physiotherapist ☐ Would the patient benefit from the following referrals?

☐ Specialist/ ☐ Occupational Therapist ☐ Psychologist ☐ Specialty Clinic

☐ Chiropractor ☐ Other ☐ Regional Evaluation Centre (REC)

Name of Referral or Facility (if known) Telephone Appointment Date dd mm yyyy

**E. Billing Section**

Health Professional Designation <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Registered Nurse (Extended Class)	Service Code <b>8M</b>	WSIB Provider ID
HST Registration No. HST Amount Billed (if applicable) \$ Service Code <b>ONHST</b> Your Invoice No.	Service Date	dd mm yyyy
Health Professional Name (please print) Address		
Telephone Fax		

Seek immediate medical assistance to initiate a *WSIB* claim.

The medical practitioner's Form 8

<b>A. Worker information</b>			
Last name		First name	
Address (number, street, apt., suite, unit)		Social Insurance Number	
City/Town		Province	Postal code
Job title/Occupation (at the time you were hurt)		Date you started with employer (dd/mm/yy)	How long have you been doing this job for this employer?
Only check if you are one of the following: <input type="checkbox"/> executive <input type="checkbox"/> elected official <input type="checkbox"/> owner <input type="checkbox"/> spouse or relative of the employer			Date of birth (dd/mm/yy)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Your preferred language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other _____		Would an interpreter be helpful? <input type="checkbox"/> yes <input type="checkbox"/> no
Are you a member of a union? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you authorize your union to represent you in this claim? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, do you consent to the disclosure of verbal claim file status information to your union representative? <input type="checkbox"/> yes <input type="checkbox"/> no	
Provide your union name and local			

<b>B. Employer information</b>	
Company/Employer name	
Address	
City/Town	Province
Your immediate supervisor's name	
Company telephone	

<b>C. Accident/illness dates and details</b>																																									
1. Date and hour of accident/Awareness of illness (dd/mm/yy) _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	2. Who did you report this accident/illness to? (name and position) _____ Telephone _____																																								
Date and hour reported to employer (dd/mm/yy) _____ <input type="checkbox"/> AM <input type="checkbox"/> PM																																									
3. Area of injury (body part) - (please check all that apply)																																									
<input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Eye(s) <input type="checkbox"/> Ear(s) <input type="checkbox"/> Teeth <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Upper back <input type="checkbox"/> Lower back <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis	<table border="0"> <tr> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/> Ankle</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Arm</td> <td><input type="checkbox"/> Arm</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Thigh</td> <td><input type="checkbox"/> Thigh</td> <td><input type="checkbox"/> Foot</td> <td><input type="checkbox"/> Foot</td> </tr> <tr> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Finger(s)</td> <td><input type="checkbox"/> Finger(s)</td> <td><input type="checkbox"/> Knee</td> <td><input type="checkbox"/> Knee</td> <td><input type="checkbox"/> Toe(s)</td> <td><input type="checkbox"/> Toe(s)</td> </tr> <tr> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Forearm</td> <td></td> <td></td> <td><input type="checkbox"/> Lower leg</td> <td><input type="checkbox"/> Lower leg</td> <td></td> <td></td> </tr> </table>	Left	Right	Left	Right	Left	Right	Left	Right	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Wrist	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hip	<input type="checkbox"/> Hip	<input type="checkbox"/> Ankle	<input type="checkbox"/> Ankle	<input type="checkbox"/> Arm	<input type="checkbox"/> Arm	<input type="checkbox"/> Hand	<input type="checkbox"/> Hand	<input type="checkbox"/> Thigh	<input type="checkbox"/> Thigh	<input type="checkbox"/> Foot	<input type="checkbox"/> Foot	<input type="checkbox"/> Elbow	<input type="checkbox"/> Elbow	<input type="checkbox"/> Finger(s)	<input type="checkbox"/> Finger(s)	<input type="checkbox"/> Knee	<input type="checkbox"/> Knee	<input type="checkbox"/> Toe(s)	<input type="checkbox"/> Toe(s)	<input type="checkbox"/> Forearm	<input type="checkbox"/> Forearm			<input type="checkbox"/> Lower leg	<input type="checkbox"/> Lower leg		
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<input type="checkbox"/> Forearm	<input type="checkbox"/> Forearm			<input type="checkbox"/> Lower leg	<input type="checkbox"/> Lower leg																																				
<input type="checkbox"/> Other: _____ Are you: <input type="checkbox"/> Left handed <input type="checkbox"/> Right handed																																									
4. Did the accident/illness happen on the employer's property or work site?	Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):																																								
5. Did it happen outside the Province of Ontario?	If yes, indicate where (city, province/state, country):																																								
6. Have you hurt this area(s) of your body before?	7. Do you have any prior related WSIB/WCB claims?																																								
	<input type="checkbox"/> no <input type="checkbox"/> yes - in Ontario <input type="checkbox"/> yes - outside Ontario																																								

Contact [accessibility@wsib.on.ca](mailto:accessibility@wsib.on.ca) if you require this communication in an alternative format.

Upload forms and supporting documents online at [wsib.ca/upload](https://wsib.ca/upload)

Mail: 200 Front Street West, Toronto, Ontario, M5V 3J1 | Toll free: 1-800-387-0750 | TTY: 1-800-387-0050 | Fax: 1-888-313-7373  
0006A (11/20)

Page 1 of 4

Complete your own documentation to initiate a **WSIB** claim.

*The worker's Form 6*

Claim Number

Please PRINT in black ink

**A. Worker Information**

Job Title/ Occupation (at the time of accident/illness - do not use abbreviations) Length of time in this position while working for you Social Insurance Number

Start > Please check if this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name First Name Is the worker covered by a Union/Collective Agreement? ☐ yes ☐ no

Address (number, street, apt., suite, unit) Worker's preferred language ☐ English ☐ French

City/Town Province Postal Code Other Date of Birth dd mm yy

Sex ☐ M ☐ F Telephone

Date of Hire dd mm yy

**B. Employer Information**

Trade and Legal Name (if different provide both) Check one: ☐ Firm Number OR ☐ Account Number Provide Number

Mailing Address Class/Subclass NAICS Code

City/Town Province Postal Code Telephone

Description of Business Activity Does your firm have 20 or more workers? ☐ yes ☐ no FAX Number

Branch Address where worker is based (if different from mailing address - no abbreviations)

City/Town Province Postal Code Alternate Telephone

**C. Accident/Illness Dates and Details**

1. Date and hour of accident/Awareness of illness dd mm yy ☐ AM ☐ PM

2. Who was the accident/illness reported to? (Name & Position) Telephone Ext.

Date and hour reported to employer dd mm yy ☐ AM ☐ PM

3. Was the accident/illness:

☐ Sudden Specific Event/Occurrence ☐ Gradually Occurring Over Time ☐ Occupational Disease ☐ Fatality

4. Type of accident/illness: (Please check all that apply)

☐ Struck/Caught ☐ Fall ☐ Slip/Trip ☐ Overexertion ☐ Harmful Substances/Environmental ☐ Motor Vehicle Incident ☐ Repetition ☐ Assault ☐ Fire/Explosion ☐ Other

5. Area of Injury (Body Part) - (Please check all that apply)

☐ Head ☐ Teeth ☐ Upper back ☐ Left ☐ Right ☐ Wrist ☐ Hip ☐ Left ☐ Right ☐ Ankle ☐ Face ☐ Neck ☐ Lower back ☐ Shoulder ☐ Arm ☐ Hand ☐ Thigh ☐ Foot ☐ Eye(s) ☐ Chest ☐ Abdomen ☐ Elbow ☐ Knee ☐ Toe(s) ☐ Ear(s) ☐ Pelvis ☐ Forearm ☐ Lower Leg

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc.). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.

The employer must file documentation to complete a WSIB claim.

The employer's Form 7



# Worker's Exposure Incident Form

## WSIB Use Only

Firm No.	Rate No.	Classification Unit Code	Reference No.
----------	----------	--------------------------	---------------

The following information will assist the Workplace Safety and Insurance Board (WSIB) in recording a workplace exposure incident. Please provide as much detail as possible to ensure that the incident is accurately recorded.

<b>Your Information</b>			
Last Name	Given Name		Maiden Name (if applicable)
Address (street address/city/town/province)			
			Postal Code
Telephone	Sex	<input type="checkbox"/> male <input type="checkbox"/> female	Date of Birth (dd/mm/yyyy)

<b>Your Employer's Information</b>	
Employer's Name (at time of incident)	Date of Hire (dd/mm/yyyy)
Describe the Nature of your Employer's Business	Your Occupation/Job Title
Employer's Address (street address/city/town/province)	
	Postal Code
Location of the Incident	

<b>Details of Incident</b>		
<b>Complete Section A</b> for an exposure to an infectious substance, or <b>Section B</b> for an exposure to chemical or other workplace substances.		
<b>Section A - (Infectious Substance)</b>	<b>Date of Exposure</b> (dd/mm/yyyy)	<b>Time of Exposure</b>
Please describe how you came into contact with the infectious substance (please check):		
<input type="checkbox"/> cut or scrape <input type="checkbox"/> body fluid splash <input type="checkbox"/> cough, sneeze <input type="checkbox"/> other (specify) _____		
Source of exposure	Area of Body Affected	
What infectious substance is suspected? (please check):		
<input type="checkbox"/> tuberculosis <input type="checkbox"/> meningitis <input type="checkbox"/> rabies <input type="checkbox"/> hepatitis <input type="checkbox"/> anthrax <input type="checkbox"/> campylobacter <input type="checkbox"/> salmonella <input type="checkbox"/> scabies <input type="checkbox"/> shingles <input type="checkbox"/> don't know <input type="checkbox"/> other (specify): _____		
If you experienced any illness related to this incident, please complete a Worker's Report of Injury/Disease (Form 6). For further information, please contact 1-800-387-0750.		

# The WSIB 3958a: *Worker's Exposure Incident Form*

..on the WSIB  
website

# Reporting exposures to the WSIB

The attached **Worker's Exposure Incident Form** (form 3958A) is intended for voluntary use when an unplanned workplace incident exposure has resulted from a leak, spill, explosion, release, or an unexpected contact with a chemical or other substance. The event may have exposed workers to an infectious, chemical or other substance. The purpose of this form is to obtain information about the exposure incident experienced by the worker should an illness or disease occur in the future.

The **Worker's Exposure Incident Form** should be completed if you have experienced an unplanned workplace exposure where there has been:

- no lost time
- no illness

**If you are experiencing any illness needing medical treatment, (such as diagnostic tests, prescribed medication or ongoing treatment) please complete a Worker's Report of Injury/Disease (Form 6).**

Occupational Health and Safety Alerts

Electronic Workplace Inspection Process (E-WIP)

▼ **Forms and Documents**

**Forms**

Assessments

Communication

Hazardous Waste Disposal

SDS Sheets

Signage and Posters

OH&S Bulletin Board

Programs, Policies, Procedures, Protocol/Guidelines

▶ Services

▶ Trainings

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▶ **Spill Incident Report**

▶ **AED/Naloxone Use Report**

***TDSB Employee's Report of a Workplace Violent Incident***



# TDSB Incident Tracking



User Name: **Chandler, Christopher**

User Role: **TDSB Staff**



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## New Incident

User Name: **Chandler, Christopher**

User Role: **TDSB Staff**



Create a new Caring and Safe Schools Incident Report.



This report is to be completed if an act of violence has occurred against a worker as defined by the Occupational Health and Safety Act.

*TDSB Employee's Report of a Workplace Violent Incident*



# TDSB Incident Tracking



[Home](#) | [Log Off](#)

## Employee's Report of a Workplace Violent Incident

User Name: Chandler, Christopher

User Role: TDSB Staff

Demographics

### Incident Reporter

Employee Number:

Number Search

First Name:

Last Name:

Name Search

Email:

Christopher.Chandler@tdsb.on.ca

Work Phone:

416-393-0070

Alt. Phone:

Mobile:

Affiliation:

Unit/Group:

### Principal/Supervisor:

Employee Number:

Number Search

First Name:

Last Name:

Name Search

Email:

Work Phone:

Mobile:

Department:

☐ I have verified the Incident Reporter's Principal/Supervisor information to be correct

*TDSB Employee's Report of a  
Workplace Violent Incident*



# TDSB Incident Tracking

[Home](#)[Log Off](#)

## New Incident

User Name: Chandler, Christopher

User Role: TDSB Staff



Caring and Safe Schools  
Incident Report

Create a new Caring and Safe Schools Incident Report.



Employee Report of a  
Workplace Violence Incident

This report is to be completed if an act of violence has occurred against a worker as defined by the Occupational Health and Safety Act.

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Report of “safe school incidents” are done on the **Safe and Caring Schools Incident Reporting Form**





## Caring and Safe Schools Incident Report

User Name: Chandler, Christopher

User Role: TDSB Staff

[Cancel](#)[Next](#)

### Demographics

**School:**

A Y Jackson Secondary School



**Learning Network**

LN08 - Marwa Hamid

**Learning Centre**

Learning Centre 2

**Student First Name**

**Student Last Name**



**Age**

**Grade**

**Gender**

[Cancel](#)[Next](#)

## Right to Refuse Work – For Teacher Members Only

### Background

The *Occupational Health and Safety Act, 1990* affirmed three important rights for workers:

1. The right to **know** about all hazards in the workplace;
2. The right to **participate** in training and consideration of issues; and
3. The right to **refuse unsafe work**.

### How serious is this issue?

Section 43 of the Act provides that:

*You may refuse to work where you have "**reason to believe**" that any equipment, machine, device, thing, or physical condition of the workplace is likely to endanger yourself or another worker.*

*You do not have to prove it is unsafe – only have "reason to believe".*

However, if you are a teacher, Regulation 857 requires that you **must** ensure the safety of students in your care **first**.

Any unsafe conditions of work should be corrected immediately.

No work should endanger anyone's health or safety.

If your concern cannot be corrected immediately using existing resources, you should exercise your legal right to refuse unsafe work.

Often threatening to refuse unsafe work is sufficient to get the problem corrected.

# The right to refuse unsafe work...

## Steps to follow in a work refusal situation

### First Stage

1. **Ensure** the safety of your student's first.
2. **Report** the circumstances to your "supervisor" (Principal, not a Department Head) and state the following:  
*"I have already ensured the safety of my students. I have reason to believe that by performing the work which I am required to do, I am likely to endanger a fellow worker or myself. Therefore, I am refusing to do the particular work in question, as permitted by the Occupational Health and Safety Act, for the following reasons ...Please investigate my concerns in the presence of my OSSTF/FEESO member on the Joint Health and Safety Committee".*
3. **Remain** in a safe place. The supervisor (Principal), in the presence of your OSSTF/FEESO Health and Safety Officer, will investigate "forthwith" (i.e. without delay).
4. **Return** to work, upon completion of the investigation, if you agree that it is now safe.

### Second Stage

After following the steps in the First Stage, if you do **not** agree that it is safe to resume work, proceed with the following steps:

At this stage, you must have **reasonable grounds** to believe the work is **dangerous**. (Reasonable grounds means that you have some objective information that causes you to believe the work is still unsafe).

1. **Remain** in a safe place or accept reasonable alternative work.
2. **Telephone** the Inspector from the local Ministry of Labour office. (Either you, the Principal or your OSSTF/FEESO Health and Safety Officer can do this). Any other worker must be informed of your work refusal, and the reasons for it, in the presence of your OSSTF/FEESO Health and Safety Officer (or their worker representative on the Joint Health and Safety Committee) before they can be given and accept the work under dispute. The Ministry of Labour Inspector will inspect the situation in the presence of your OSSTF/FEESO Health and Safety officer and your presence, if you wish. The Inspector will make a report in writing.
3. You must **return** to work, if the Inspector deems it safe.
4. **Appeal** of the Inspector's decision can be made by any of the parties involved.





# A Scenario...

## Scenario:

You have a new contract teaching job, teaching a Phys. Ed. timetable. One day in the gym, students are running group relays with different intervals/tasks spread around the gym. One of the intervals involves students throwing footballs between team members. A student arrives late. You encourage them to hurry up and join a team. The student tells you off, asking who you are, but you brush it aside, encouraging them to participate. You are walking around the gym floor, cheering students on, making notes on their participation. Suddenly there is a sharp ringing in in your ear. The next thing you know, you're lying on your back, looking up at a circle of student faces, and the kids are asking, "Are you okay?" A student says, "I can't believe they threw the ball at you like that." WWYD?

# What to do if you are assaulted at work:

1. Immediately report the incident to the administration and to the police
2. Seek medical attention ASAP
3. Notify your Union ASAP
4. Document what took place before, during, and after the assault



# What to do if you are assaulted at work:

2. Seek medical attention ASAP [WSIB form 8]
4. Document what took place before, during, and after the assault [ERAI, WSIB Form 6, ERWVI, Health and Safety Concern Form, Safe and Caring Schools Form]

# Under the OHSA, workplace violence is defined as:

- (a) the exercise of **physical force** by a person **against a worker in a workplace that causes or could cause physical injury** to the worker;
- (b) an **attempt** to exercise physical force against a worker in a workplace that could cause physical injury to the worker;
- (c) a **statement or behaviour** that it is reasonable for a worker to interpret as **a threat** to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

# Duties of employers under the *Occupational Health and Safety Act*

25 (2) Without limiting the strict duty imposed by subsection (1), an employer shall,

- (a) provide **information, instruction and supervision** to a worker to protect the health or safety of the worker;
- (d) **acquaint a worker** or a person in authority over a worker **with any hazard in the work** and in the handling, storage, use, disposal and transport of any article, device, equipment or a biological, chemical or physical agent;
- (h) take **every precaution reasonable in the circumstances** for the protection of a worker



**DSB Name**

**NOTIFICATION OF POTENTIAL RISK OF PHYSICAL INJURY  
(Truncated Student Safety Plan)**

This sample template is provided as a resource, for the consideration of each school board in developing their own form. Each school board is responsible for ensuring that the version of the form they use, and their procedures around the form, are compliant with their responsibilities under *MFIPPA*, *OHSA*, and other legislation.

This form is intended to facilitate the school board's duty under s.32.0.5 (3) of the *Occupational Health and Safety Act* to provide information to workers related to a risk of workplace violence from a person with a history of violent behaviour. This form must be completed by a principal or vice principal and provided to a worker at school if: a) the worker can be expected to encounter that person in the course of his or her work; and b) the risk of workplace violence is likely to expose the worker to physical injury.

**Board Policy/ Procedure**

*Hyperlink to Board Policy and Procedure*

**HOW TO SUMMON IMMEDIATE ASSISTANCE**

**Disclosure to  
workers of  
known risks of  
workplace  
violence  
required by the  
*Occupational  
Health and  
Safety Act***

IDENTIFYING INFORMATION	
Student's Name:	PHOTO
School:	
Department/Room Number:	

BRIEF DESCRIPTION OF BEHAVIOUR(S) THAT PRESENTS A RISK OF PHYSICAL INJURY
The description of the behaviours should be outlined in three sections:
Known Triggers
Indicators of Escalation (Physical signs/cues that the student is about to become aggressive or assaultive).
Indicators of Full Escalation

STRATEGIES FOR AVOIDING A RISK OF PHYSICAL INJURY :	
DO:	DO NOT:

EMERGENCY AND INTERVENTION STRATEGIES

Completed by \_\_\_\_\_

Date \_\_\_\_\_

(Principal or Designate)

Retain in a central and secure location.

**Disclosure to  
workers of  
known risks of  
workplace  
violence**  
required by the  
*Occupational  
Health and  
Safety Act*

# No Reprisals, under the OHSA

**50** (1) No employer or person acting on behalf of an employer shall,

- (a) **dismiss or threaten to dismiss** a worker;
- (b) **discipline or suspend or threaten to discipline or suspend** a worker;
- (c) **impose any penalty** upon a worker; or
- (d) **intimidate or coerce** a worker,

because the worker has **acted in compliance with this Act**

When in doubt, always turn to your Union first.





# When in doubt, always turn to your Union first.

You can find your Health and Safety Inspector by entering your school name in the search window below.

Health and Safety Inspectors by School:

All Schools ▼

**Denis Da Ros**

*Health & Safety Inspector -  
OSSTF Toronto Teachers  
Bargaining Unit*

**Eitan Laufer**

*Health & Safety Inspector -  
OSSTF Toronto Teachers  
Bargaining Unit*

**Soma Srivastava**

*Health and Safety - OSSTF  
Toronto Teachers Bargaining  
Unit*

# Questions?