

<b>Date of Issue</b>	September 2010
<b>Original Date of Issue</b>	September 1985
<b>Subject</b>	<b>REPORTING OF WORKPLACE INJURY/ILLNESS</b>
<b>References</b>	Workplace Safety & Insurance Act Occupational Health & Safety Act (R.S.O. 1990) APM A4001 – Return to Work by Ill and Injured Employees APM A4003 – Occupational Health & Safety Procedure
<b>Links</b>	HS03-01 – First Aid Requirements HS03-02 – Injuries to Employees - Critical and Fatal HS03-03 – Supervisors' Accident Investigation FORM A4002 – 1 – Report of Workplace Injury/Illness
<b>Contact</b>	Human Resource Services

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**1. Purpose**

- 1.1 This Administrative Procedures Memorandum (APM) provides guidance to employees of the Simcoe County District School Board (Board) for reporting work related injury and illness.

**2. General**

- 2.1 The Board recognizes the need to provide a healthy and safe working environment for all of its employees. Reporting work related injury/illness is governed in Ontario by two pieces of legislation: The *Workplace Safety and Insurance Act, 1997*, and the *Occupational Health & Safety Act (R.S.O. 1990)*.
- 2.2 The Workplace Safety & Insurance Board (WSIB) is the Ontario organization that is mandated by the *Workplace Safety & Insurance Act* to independently administer the workplace injury/illness claims of Ontario workers. It provides adjudication of employees claims for benefits covering health care and loss of earnings.

**3. Definitions**

- 3.1 First Aid means the emergency care or treatment of a minor injury on-site, administered under legislated first aid requirements, with the aim of preventing an injury or illness from becoming worse.

- 3.2 Health Care means the employee has required professional treatment given by or under the supervision of a physician at a medical facility or in transit to such a facility. This can also include treatment by a dentist, physiotherapist, chiropractor or registered nurse (extended class). The employee is able to return to his or her next scheduled work shift.
- 3.3 Lost Time means that the employee has required health care and has been unable to report for the start of the next scheduled work shift.
- 3.4 Critical Injury means an injury, as defined by the Occupational Health and Safety Act, that:
  - 3.4.1 places life in jeopardy;
  - 3.4.2 produces unconsciousness;
  - 3.4.3 results in substantial loss of blood;
  - 3.4.4 involves the fracture of an arm or leg but not a finger or toe;
  - 3.4.5 involves the amputation of a leg, arm, hand or foot but not a finger or toe;
  - 3.4.6 consists of burns to a major portion of the body;
  - 3.4.7 causes the loss of sight in an eye.

#### **4. WSIB Benefits Coverage**

- 4.1 All employees of the Board, whether temporary or permanent, are eligible for benefits when they are deemed by WSIB to have suffered an injury/illness arising out of and in the course of their official duties.

#### **5. WSIB Legislated Requirements**

- 5.1 To comply with legislation, when an employee is injured at work or develops an occupational illness, the Board as the employer is required to:
  - 5.1.1 Keep a record of all circumstances of injuries that require first aid, health care or result in lost time from work;
  - 5.1.2 Complete and submit Employer's Report of Injury/Disease (Form 7) to WSIB within three (3) business days of becoming aware of a work-related injury/illness that requires health care or lost time from work;
  - 5.1.3 Offer early and safe return to work programs to injured/ill employees using functional abilities information or WSIB Standard Medical Precautions;
  - 5.1.4 Pay wages to the employee for the full shift on the day of injury without loss of sick credit;
  - 5.1.5 Pay transportation costs by such means as ambulance or taxi for initial medical treatment on the day of injury.
- 5.2 Legislation also requires WSIB to assess financial penalties to employers who fail to submit injury/illness reports to them within three (3) business days of becoming aware of an injury/illness that requires health care or lost time from work.

- 5.2.1 It should be noted that the time period begins on the day the employee informs a person in a position of authority (principal, vice-principal, manager, or supervisor) at the work location about the injury/illness. It is the responsibility of the person to whom the injury is reported, to ensure that:
- 5.2.1.1 the worker completes the Report of Workplace Injury/Illness (**FORM A4002-1**)
  - 5.2.1.2 the completed form is faxed immediately to (705)728-2305 or e-mailed to [workplaceincident@scdsb.on.ca](mailto:workplaceincident@scdsb.on.ca) within one (1) working day of injury/illness.

## 6. Reporting Work Related Injury/Illness

- 6.1 All workplace injuries/illnesses shall be reported and all details shall be recorded on the Report of Workplace Injury/Illness (FORM A4002 – 1) and the completed form shall be submitted within one (1) working day of injury/illness to Human Resource Services – Compensation & Wellness as directed on the form, in order for the injury to be reported to WSIB within three (3) business days as required under item 5.1.2.
- 6.1.1 Employees are required to complete pages 1 and 2 of the Report of Workplace Injury/Illness (**FORM A4002 - 1**).
  - 6.1.2 Supervisors are required to complete an accident investigation and record the details on page 3 of the Report of Workplace Injury/Illness (**FORM A4002 - 1**). If an employee is unable to complete the Report of Workplace Injury/Illness due to the severity of the injury or ongoing absence from the workplace, the supervisor shall complete the entire form using the known details of the injury.
    - 6.1.2.1 In addition, supervisors are responsible to ensure that injury/illness reports are submitted within one (1) working day for a health care or lost time incident in order for the injury to be reported to WSIB as required under item 5.1.2. Repeated late submission of injury reports may be reviewed with the appropriate superintendent and any financial penalties assessed to the Board by WSIB may be passed on to the school or department budget.
- 6.2 When an employee has a critical injury or is fatally injured as defined in the *Occupational Health and Safety Act* (item 3.4), several communication steps must take place before the Report of Workplace Injury/Illness (**FORM A4002 - 1**) is prepared. These steps are outlined in *Health & Safety Procedure* (HS 03-02) Injuries to Employees – Critical and Fatal.

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***Issued under the authority of the Director of Education***



**REPORT OF WORKPLACE INJURY OR ILLNESS**

**FOR CRITICAL INJURIES CALL HEALTH & SAFETY IMMEDIATELY AT 705-734-6363 ext. 11314 or 11346**

**INSTRUCTIONS:**

- Pages 1 & 2 to be completed by employee and immediately provide form to your supervisor to complete Page 3
- Please fax completed form to (705) 728-2305 within one (1) working day of the incident

Last name: _____		First name: _____	
Address: _____			
Employee #: _____		Date of birth (dd/mm/yyyy) _____	
Home telephone: _____		Work telephone: _____ or e-mail _____	
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Casual           Regular hours of work from _____ <input type="checkbox"/> am <input type="checkbox"/> pm to _____ <input type="checkbox"/> am <input type="checkbox"/> pm			
Work location: _____		Occupation _____	
Supervisor's name: _____		Supervisor's telephone: _____	
<b>A. Injury/Illness Dates and Details</b>			
1. Date and hour of injury/Awareness of illness		dd mm dd	Time <input type="checkbox"/> am <input type="checkbox"/> pm
Date and hour reported to employee		dd mm dd	Time <input type="checkbox"/> am <input type="checkbox"/> pm
2. Who was the injury/illness reported to? (Name & Position)		Telephone _____ Ext. _____	
3. Was the injury/illness		4. Type of injury/illness <b>(Please check all that apply)</b>	
<input type="checkbox"/> Sudden Specific Event/Occurrence <input type="checkbox"/> Gradually Occurring Over Time <input type="checkbox"/> Occupational Disease <input type="checkbox"/> Fatality		<input type="checkbox"/> Struck/Caught <input type="checkbox"/> Fall <input type="checkbox"/> Motor Vehicle Incident <input type="checkbox"/> Overexertion <input type="checkbox"/> Slip/Trip <input type="checkbox"/> Exposure to Harmful Substances <input type="checkbox"/> Repetition <input type="checkbox"/> Assault <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Other _____	
5. Area of Injury (Body Part) <b>(Please check all that apply)</b>			
<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Upper back	<input type="checkbox"/> Left <input type="checkbox"/> Right
<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Lower back	<input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/> Hip <input type="checkbox"/> Ankle <input type="checkbox"/>
<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Arm <input type="checkbox"/> Hand <input type="checkbox"/> Thigh <input type="checkbox"/> Foot <input type="checkbox"/>
<input type="checkbox"/> Ear(s)	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Elbow	<input type="checkbox"/> Finger(s) <input type="checkbox"/> Knee <input type="checkbox"/> Toe <input type="checkbox"/>
<input type="checkbox"/> Other _____		<input type="checkbox"/> Forearm	<input type="checkbox"/> Lower Leg <input type="checkbox"/>
6. Describe what happened to cause the injury/illness and what you were doing at the time (e.g. lifted a 50 lb. box, slipped on wet floor, repetitive movements). Include what the injury is (e.g. knee pain, cut leg, irritated throat). <b>BE AS DETAILED AS POSSIBLE.</b>			
_____			
_____			
_____			
7. Did the injury/illness happen on school board premises? <input type="checkbox"/> Yes <input type="checkbox"/> No      Specify where (e.g. hallway, gymnasium, parking lot, etc.) _____			





PAGE 3 TO BE COMPLETED BY SUPERVISOR

Employee's Name: \_\_\_\_\_

If this is a critical injury – contact the Health and Safety Officer IMMEDIATELY at (705) 734-6363 ext. 11314 or 11346

Please conduct an independent investigation when completing this page. Your investigation should include an interview with the injured employee and a physical investigation of the incident site.

FAX COMPLETED FORM TO: HR Services Department - Compensation & Wellness, 705-728-2305 within one (1) working day of notification of health care or lost time. For all other incidents, please complete form within three (3) working days of the incident.

E. Incident Investigation/Prevention

From your investigation of this injury what were the circumstances at the time of the incident?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Preventive Action: Please check all that apply:

- |   |   |
|---|---|
| 1. <input type="checkbox"/> Re-instruction of Person Involved | 12. <input type="checkbox"/> Re-assignment of Person                      |
| 2. <input type="checkbox"/> Order Job Safety Analysis         | 13. <input type="checkbox"/> Improved Personal Protective Equipment       |
| 3. <input type="checkbox"/> Repair or Replacement             | 14. <input type="checkbox"/> Installation of Guard or Safety Device       |
| 4. <input type="checkbox"/> Actions to Improve Design/Method  | 15. <input type="checkbox"/> Check with Manufacturer                      |
| 5. <input type="checkbox"/> Discipline of Persons Involved    | 16. <input type="checkbox"/> Workplace Inspection                         |
| 6. <input type="checkbox"/> Consult with Health & Safety      | 17. <input type="checkbox"/> Consult with Joint Health & Safety Committee |
| 7. <input type="checkbox"/> Consult with Ministry of Labour   | 18. <input type="checkbox"/> Incident Under Investigation                 |
| 8. <input type="checkbox"/> Correction of Congested Areas     | 19. <input type="checkbox"/> Inform Department Supervisors                |
| 9. <input type="checkbox"/> Improve Housekeeping Procedure    | 20. <input type="checkbox"/> Develop Written Safe Working Procedures      |
| 10. <input type="checkbox"/> Ergonomic Assessment             | 21. <input type="checkbox"/> Develop Inspection Form and Routine          |
| 11. <input type="checkbox"/> Provide Proper Ventilation       | 22. <input type="checkbox"/> Other _____                                  |

What steps can be taken to prevent a similar injury?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe how/when the above steps can/will be implemented.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature