

Date of Issue	September 2007
Original Date of Issue	September 1985
Subject	REPORTING OF WORKPLACE INJURY-ILLNESS
References	Workplace Safety & Insurance Act Occupational Health & Safety Act (R.S.O. 1990) Occupational Health & Safety Procedure
Links	FORM A2320 - 1
Contact	Human Resource Services

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 employee claim for benefits covering health care and loss of earnings.

3. Definitions

3.1 First Aid

- 3.1.1 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 Injury/Illness



3.2.1 A health care injury/illness 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 and can also include treatment by a dentist, physiotherapist or other practitioner. This type of injury/illness the employee is able to return to his or her next scheduled work shift.

3.3 Lost Time Injury/Illness

3.3.1 A lost time injury/illness 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

3.4.1 The *Occupational Health and Safety Act*, defines a critical injury as an injury that:

- 3.4.1.1 places life in jeopardy;
- 3.4.1.2 produces unconsciousness;
- 3.4.1.3 results in substantial loss of blood;
- 3.4.1.4 involves the fracture of an arm or leg but not a finger or toe;
- 3.4.1.5 involves the amputation of a leg, arm, hand or foot but not a finger or toe;
- 3.4.1.6 consists of burns to a major portion of the body;
- 3.4.1.7 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 business days of becoming aware of a work-related injury/illness that requires health care or lost time from work;



- 5.1.3 Offer return to work programs to injured/ill employees using functional abilities information;
 - 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 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 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 A2320 – 1)
 - 5.2.1.2 the complete form is faxed immediately to Human Resource Services Officer – WSIB and Attendance Support at fax (705) 728-2265

6. Reporting Work Related Injury/Illness

- 6.1 All workplace injuries/illnesses shall be reported. The injury/illness details shall be recorded on Report of Workplace Injury/Illness (FORM A2320 – 1). The completed form shall be submitted immediately to the disability team as directed on the form, in order for the injury to be reported to WSIB within three business days as required under item 5.1.2.
- 6.1.1 Employees are required to complete pages 1 and 2 of Report of Workplace Injury/Illness (FORM A2320 - 1).
 - 6.1.2 Supervisors are required to complete an accident investigation and record the details on page 3 of Report of Workplace Injury/Illness (FORM A2320 - 1). If an employee is unable to complete the form 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 immediately 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 shall take place before the Report of Workplace Injury/Illness (FORM A2320 - 1) is prepared. These steps are outlined in *Occupational Health & Safety Procedure*.

First Issued September 1985
Revised September, 2007

Issued under the authority of the Director of Education

Reporting of Workplace Injury/Illness
PAGES 1 & 2 TO BE COMPLETED BY EMPLOYEE

INSTRUCTIONS TO EMPLOYEE:

- Complete Pages 1 & 2, including signature and date.
- Immediately give the form to your supervisor to complete Page 3.

Last name _____ First name _____
 Address _____
 Employee # _____ Date of birth (dd/mm/yyyy) _____
 Home telephone _____ Work telephone _____ or e-mail _____
 Full Time Part Time Casual Regular hours of work from _____ a.m. p.m. to _____ a.m. p.m.
 Work location _____ Occupation _____
 Supervisor's name _____ Supervisor's telephone _____

A. Injury/Illness Dates and Details

1. Date and hour of injury/Awareness of illness. dd mm yy Time <input type="checkbox"/> am <input type="checkbox"/> pm / / / / / / Date and hour reported to employer dd mm yy 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 <input type="checkbox"/> Sudden Specific Event/Occurrence <input type="checkbox"/> Gradually Occurring Over Time <input type="checkbox"/> Occupational Disease <input type="checkbox"/> Fatality	4. Type of injury/illness (Please check all that apply) <input type="checkbox"/> Struck/Caught <input type="checkbox"/> Fall <input type="checkbox"/> Slip/Trip <input type="checkbox"/> Overexertion <input type="checkbox"/> Exposure to Harmful Substances <input type="checkbox"/> Motor Vehicle Incident <input type="checkbox"/> Repetition <input type="checkbox"/> Assault <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Other																																																							
5. Area of Injury (Body Part) (Please check all that apply) <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Teeth</td> <td><input type="checkbox"/> Upper back</td> <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"/> Face</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Lower back</td> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Ankle</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Eye(s)</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Arm</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Thigh</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Foot</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Ear(s)</td> <td><input type="checkbox"/> Pelvis</td> <td></td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Finger(s)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Knee</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Toe</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td><input type="checkbox"/> Lower Leg</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Upper back	Left	Right	Left	Right	Left	Right	Left	Right	<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Lower back	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<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"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/> Thigh	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/> Ear(s)	<input type="checkbox"/> Pelvis		<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/> Finger(s)	<input type="checkbox"/>	<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/> Toe	<input type="checkbox"/>	<input type="checkbox"/> Other _____			<input type="checkbox"/> Forearm	<input type="checkbox"/>			<input type="checkbox"/> Lower Leg	<input type="checkbox"/>		
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6. Describe what happened to cause the injury/illness and what you were doing at the time (lifted a 50 lb. box, slipped on wet floor, repetitive movements). Include what the injury is (for example, knee pain, cut leg, irritated throat). BE AS DETAILED AS POSSIBLE. _____ _____ _____																																																								
7. Did the injury/illness happen on school board premises? Specify where (hallway, gymnasium, parking lot, and so forth). <input type="checkbox"/> Yes <input type="checkbox"/> No																																																								
8. Did the injury/illness happen outside the Province of Ontario? If Yes , where (location, city, province/state, country) <input type="checkbox"/> Yes <input type="checkbox"/> No																																																								



9. Were there any witnesses or other employees involved in this injury/illness? Yes No If **Yes**, provide name(s), position(s), and work phone number(s)

10. Have you had any prior similar or related problem, injury or condition? Yes No If **Yes**, please explain

B. Health Care

1. Did you receive health care for this injury? Yes No If **Yes**, when: dd / mm / yy

2. When did you tell the supervisor that you received health care? dd / mm / yy

3. Where were you treated for this injury? **(Please check all that apply)**

On-site first aid Please provide name and phone number of first aid provider: _____

Ambulance Emergency department Admitted to hospital Health Professional office Clinic Other

Name and address of the health professional or facility that treated you:

Name: _____

Address/Phone Number: _____

C. Lost Time - No Lost Time

1. Please choose one of the following: **After the day of the injury/awareness of illness, did you:**

Return to **regular job**.

Return to **modified work**.

Lose time as follows:

Provide date you first lost time dd mm yy Date you returned to work dd mm yy

regular work

modified work

D. Work Schedule

What are your regular hours of work **(Complete either A or B.)**

(A.) Regular Schedule – Indicate normal work days and hours. **Example:** Monday to Friday, 40 hours

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

S	M	T	W	T	F	S
	8	8	8	8	8	

Or

(B.) Varied or Irregular Work Schedule - Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the injury/illness. **(Casual or Temporary)**

	Week 1	Week 2	Week 3	Week 4
From/To Dates (dd/mm/yy)	/	/	/	/
Total Hours Worked				
Total Shifts Worked				

Employee Signature _____

Date _____



PAGE 3 TO BE COMPLETED BY SUPERVISOR

INSTRUCTIONS TO SUPERVISOR:

- **If this is a critical injury** [definition: places life in jeopardy, causes a broken arm or leg (but not finger or toe), results in heavy blood loss, produces unconsciousness, loss of sight in one or both eyes, or produces widespread burns], please contact the Health and Safety Officer **IMMEDIATELY**.
- 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: WSIB CLAIMS MANAGEMENT OFFICER, 705-728-2265, within 48 hours of the injury/illness.**

E. Incident Investigation/Prevention

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

Preventive Action: Please choose one or more of the following:

- | | |
|---|---|
| 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.

Please involve the Health & Safety Representative for your workplace in your incident investigation.

Work Location

Date

Supervisor Signature