

*To Be Completed by Supervisor*

**A) GENERAL INFORMATION**

1. School Number	2. School Name	3. School Phone Number
		4. Worker's Extension

**B) INJURED WORKER IDENTIFICATION**

5. Last Name	6. First Name	7. Sex	8. Phone Number	9. Date of Birth <small>day   mth   yr</small>
10. Address (No., Street, Apt.)	11. City/Town	12. Postal Code		13. Date of Employment <small>day   mth   yr</small>
14. Occupation  <input type="checkbox"/> Permanent <input type="checkbox"/> Casual	15. Normal Hours of Work a.m. to p.m. <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		16. Social Insurance No.	

**C) INCIDENT INVESTIGATION - Sequence of events leading to the accident**

17. Date & Hour of Incident <small>day   mth   yr   am/pm</small>	18. Date & Hour Reported to Supervisor <small>day   mth   yr   am/pm</small>	19. Name & Address of <b>Healthcare Provider</b> - Do <b>Not</b> Complete if Healthcare <b>Not</b> Sought		
20. INJURY CLASSIFICATION (check one)		Date Healthcare received for this injury <small>day   mth   yr   am/pm</small>		
<p><b>Lost Time</b>    <input type="checkbox"/> Injury that requires professional medical treatment <b>AND</b> involves an absence from work beyond the day of the incident.</p> <p><b>No Lost Time</b>    <input type="checkbox"/> Employee sought medical attention which includes a MD, Chiropractor, Physiotherapist.</p> <p><b>First Aid</b>        <input type="checkbox"/> Administered by School Personnel.</p> <p><b>Record Only</b>    <input type="checkbox"/> Injury sustained but <b>NOT</b> requiring first-aid or medical treatment.</p> <p><b>Near Miss</b>        <input type="checkbox"/> Personal injury was not inflicted.</p>		<p>If this is a Lost Time Incident, the employee's return-to-work date must be reported to Human Resources</p> <p style="text-align: center;">For "Lost Time" state last date &amp; hour worked. <small>day   mth   yr   am/pm</small></p>		

**NOTE: FOR CRITICAL INJURIES ALSO, FOLLOW HEALTH & SAFETY PROCEDURE #1 (see reverse side)**

21. In detail, trace the sequence of events that caused the injury.

22. Describe the nature of the injury including par(s) of the body involved, specifying left or right side. (ie.: cut baby finger, left hand)

23. If applicable, identify the size, weight and type of equipment or materials involved.

24. Location of Incident. Where on the premises did the incident occur?

25. What conditions contributed to the incident? (ie.: hazardous conditions, lack of equipment, external factors, situation at time of incident, lack of training)

26. Provide names of witnesses or persons having knowledge of the incident.

Witnesses:	Persons Having Knowledge:
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**D) WSIB CLAIM INFORMATION**

27. Has the employee had a previous similar disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	28. If "yes", provide details.
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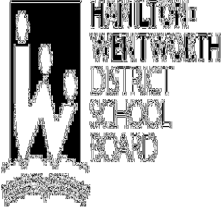
**E) DAMAGE TO PROPERTY - (if any)**

29. Was there any damage to property? <input type="checkbox"/> Yes <input type="checkbox"/> No	30. If "yes", what was damaged and what was the nature and extent of damage?
31. Was a Maximo Work Order filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**F) PREVENTATIVE ACTION - taken by Supervisor**

32. MEASURES TAKEN BY SUPERVISOR TO PREVENT RECURRENCE:	
I verify that the information provided above has been obtained and presented in accordance with the Hamilton-Wentworth District School Board incident Investigation Reporting Procedures.	
Supervisor's Signature:	The employee's signature on this document only signifies that the employee has received a copy of the report.
Date: <small>day   mth   yr</small>	Employee's Signature:      Date: <small>day   mth   yr</small>

**FORWARD ORIGINAL TO HUMAN RESOURCES WITHIN 24 HOURS OF DATE INCIDENT WAS REPORTED (SEE BLOCK 18)**



## HEALTH & SAFETY PROCEDURE

Reporting Serious or Critical Injuries, and Fatalities, SP-1  
October 2006 (Revised)

To: All School Administrators and Administrative  
Managers/Supervisors

Page 1 of 1

**Purpose:** To outline additional reporting requirements in the event of injury.

**Determining the Nature of an Incident:**

The following criteria define an incident that requires action **in addition** to completing the *Supervisor's Incident Investigation Report (SIIR)*:

1. Where a worker is killed or critically injured (see "Critical Injury Defined" below).
2. Where a worker suffers loss of a finger or toe.
3. Where a supervisor becomes aware that a worker suffers from a terminal occupational disease.
4. Where an incident or near-miss incident results in equipment damage in excess of \$10,000.
5. Any other incident that may be considered serious.

**Additional Action:**

In the event of a serious or critical injury you **must**:

1. Get the injured employee stabilized and off to the hospital (call 911 for police, fire, ambulance).
2. Clear the area of people, lock out the machine and/or rope off the area and preserve ALL evidence until the incident is investigated and, in the event of a critical injury, cleared by the Ministry of Labour.

**NOTE:** Failure to secure the accident scene can result in a charge by the Ministry of Labour.

3. Contact the Health & Safety Officer **immediately** should such an incident occur.

PHONE: 905-318-8878 x248  
PAGER: 905-572-4855

The Health & Safety Officer will **immediately** notify the Ministry of Labour and the appropriate federation/union Certified Worker Representative of the Joint Health and Safety Committee, as required under the *Occupational Health and Safety Act*.

**NOTE:** If you cannot reach the Health & Safety Officer, please contact the appropriate individuals directly.

Ministry of Labour: 905-577-6221  
Certified Worker Representative: see yearly Joint Health & Safety Committee Membership List

4. Collect witness names and statements.

**Critical Injury Defined:**

For the purposes of the *Occupational Health and Safety Act* and *Regulation 834*, "critically injured" means an injury of a serious nature that:

- a) places life in jeopardy;
- b) produces unconsciousness;
- c) results in a substantial loss of blood;
- d) involves the fracture of a leg or an arm but not a finger or toe;
- e) involves the amputation of a leg, arm, hand, foot but not a finger or toe;
- f) consists of burns to a major portion of the body; or
- g) causes the loss of sight in an eye.

**NOTE:** a critical injury that occurs to a non-employee (ie./ student, volunteer, visitor) must also be reported to the Ministry of Labour, as required under the *Occupational Health and Safety Act*. Please complete an OSBIE Incident Report Form for non-employee incidents and submit to Accommodation & Planning Department.



# SUPERVISOR'S ***I***NCIDENT ***I***NVESTIGATION ***R***EPORT Continuation Form

*To Be Completed by Supervisor*

**GENERAL INFORMATION**

Last Name	First Name	School	School Phone Number
			Worker's Extension

Date & Time of Each Incident	Date & Time Reported to Supervisor	Describe sequence of events that caused the injury and describe nature of the injury including the body parts involved.
Lost Time <input type="checkbox"/> No Lost Time <input type="checkbox"/> First Aid <input type="checkbox"/> Record Only <input type="checkbox"/> Near Miss <input type="checkbox"/> <small>See SIIR for definitions</small>		
Lost Time <input type="checkbox"/> No Lost Time <input type="checkbox"/> First Aid <input type="checkbox"/> Record Only <input type="checkbox"/> Near Miss <input type="checkbox"/> <small>See SIIR for definitions</small>		
Lost Time <input type="checkbox"/> No Lost Time <input type="checkbox"/> First Aid <input type="checkbox"/> Record Only <input type="checkbox"/> Near Miss <input type="checkbox"/> <small>See SIIR for definitions</small>		
Lost Time <input type="checkbox"/> No Lost Time <input type="checkbox"/> First Aid <input type="checkbox"/> Record Only <input type="checkbox"/> Near Miss <input type="checkbox"/> <small>See SIIR for definitions</small>		
Lost Time <input type="checkbox"/> No Lost Time <input type="checkbox"/> First Aid <input type="checkbox"/> Record Only <input type="checkbox"/> Near Miss <input type="checkbox"/> <small>See SIIR for definitions</small>		

Employee's Signature:	If any of the above incidents required Health Care or Lost Time please complete— <u>Do Not Complete if Healthcare Not Sought</u>			
Supervisor's Signature:	Name & Address of Healthcare Provider:	If this is a Lost Time Incident, the employee's return-to-work date must be reported to Human Resources		
		Date Healthcare received for this injury	day	mth
		For "Lost Time" state last date & hour worked.	yr	am/pm
			day	mth
			yr	am/pm

**SIIR Continuation Form—To be used for multiple accident occurrences on the same day.  
FORWARD ORIGINAL COPY TO HUMAN RESOURCES WITHIN 24 HOURS OF DATE INCIDENT WAS REPORTED**