Trillium Lakelands
DISTRICT SCHOOL BOARD

FOR THE EMPLOYEE

WSIB Employee Injury Reporting Kit

Enclosed:

—> Employee's Injury Reporting Checklist
—> Letter to Health Professional
—> Employee Workplace Incident/Accident/Illness Reporting Form
—> Form 8
—> Functional Abilities Form (FAF)

This package must go with the employee if they are seeking **medical attention**

Corporate Office
Box 420, 300 County Rd. 36, Lindsay, ON K9V 4S4
(705) 324-6776 **FAX:** (705) 328-2036

Trillium Lakelands
DISTRICT SCHOOL BOARD

Employee
Injury Reporting Checklist
WSIB reporting and Early and Safe Return to Work

As an injured worker you are responsible for the following:

- ☐ **1.** Contact your supervisor as soon as possible after an injury occurs and/or if you have seeked medical attention.
- ☐ **2.** Complete and submit the Employee Incident/Accident/Illness Reporting Form within 24 hours of the injury.
- ☐ **3.** Take this package to your health care provider and advise that your employer offers modified duties.
- ☐ **4.** Two (2) forms have been provided in this package. The Form 8 will be completed by the medical practitioner if this is your first visit. If this is a follow up appointment, the Functional Abilities Form (FAF) will be completed.
- ☐ **5.** Please return the completed form to your supervisor within 24 hours of your medical appointment. If the Form 8 was completed, all that is required to be provided is Page 2. If the Functional Abilities Form (FAF) was completed, both pages need to be provided.
- ☐ **6.** WSIB will send you a Worker's report of Injury/disease (Form 6) in the mail. Once you have completed it, a copy is to be sent to you supervisor and to WSIB.
- ☐ **7.** Maintain communication with your supervisor/ H&S WSIB Coordinator throughout the claim period.
- ☐ **8.** Provide information and updates as required by the Workplace Safety and Insurance Board (WSIB).

Your assistance and cooperation is required by providing medical documents and participating in your early and safe return to work meetings.

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Trillium Lakelands
DISTRICT SCHOOL BOARD

Dear Health Professional,

Trillium Lakelands District School Board is committed to the health and well-being of our employees and to ensuring a safe and healthy work environment. If an employee is injured, the priority is to ensure appropriate medical care**. It is also our goal to support employees in their return to work at the earliest opportunity by provide modified work**. To this end the Board, through its Return to Work Program, works with employees and their treating physician(s) to develop an appropriate return to work plan. This may include modified duties, graduated hours and/or flexibility to attend treatment programs.

To assist the Board in developing an appropriate return to work plan, we would ask that you complete the Form 8 or Functional Abilities Form (FAF) indicating the anticipated return to work date as well as the employee's medical limitations, restrictions /functional abilities and the date of the followed appointment.

The information on page 2 of the Form 8 or the FAF form will help us establish a safe return to work and it is necessary that we receive the medical as soon as possible, preferably to accompany the employee back to us today. If it is not accompanying the employee please fax it to 705-324-8913.

I can respect that you are extremely busy and therefore sincerely appreciate your efforts and attention to this matter. If you have any questions please do not hesitate to call me at (705) 324-6776 ext. 22135.

Yours truly,

Brock Easterling
Health & Safety / WSIB Coordinator
Trillium Lakelands District School Board

TRILLIUM LAKELANDS DISTRICT SCHOOL BOARD

EMPLOYEE WORKPLACE INCIDENT / ACCIDENT / ILLNESS REPORTING FORM

IMPORTANT: All employee work-related incidents/accidents/illnesses must be reported on this form and sent to the Human Resources Department, Lindsay Office (Fax # 705-324-8913 or emailed to Injury Reports in First Class), **IMMEDIATELY**. Original form is to be forwarded by courier. If additional space is required, attach separate sheet noting specific section number(s).
PLEASE NOTIFY YOUR PRINCIPAL / SUPERVISOR OF YOUR INCIDENT / ACCIDENT / ILLNESS IMMEDIATELY

1. Employee Name:			2. Occupation:	
3. School/Work Site:			4. Specific Location of Incident/Accident (parking lot, hallway, gym etc..):	
5. Date of Incident (d/m/y):	6. Time of Incident:	7. Date Reported (d/m/y):	8. Time Reported:	9. Who did you report the Incident/Accident/Illness to?

10. Type of Incident / Accident / illness: (Please check all that apply) (See reverse for further explanation)

☐ Struck by or Contact by	☐ Lifting or Assisting High Needs Student	☐ Over Exertion / Strain
☐ Struck Against or Contact with	☐ Lifting Equipment / Furniture	☐ Field Trip
☐ Caught In, Under, On, Between	☐ Student Aggression / Violence	☐ Slip / Trip/ No Fall
☐ Exposure	☐ Workplace Violence	☐ Slip / Trip / Fall

11. Describe what you were doing at the time of the incident and the sequence of events that lead to your workplace incident/ accident or illness:

12. Please list Body part(s) injured: (State left or right, if applicable)

13. Describe the materials or equipment being used at the time of the Incident / Accident / Illness:

14. Provide name and telephone number of any witnesses: (if known).

15. Did you receive first aid at the workplace? **Yes** ☐ **No** ☐

16. Are you going to see a Doctor / Chiropractor / Physiotherapist in regards to your workplace Incident / Accident/ illness? **Yes** ☐ **No** ☐
Where treated?

17. Have you had any similar or related problem, injury or condition? **Yes** ☐ **No** ☐
If yes, provide details:

18. Was any individual who does not work for TLDSB totally or partially responsible for your injury or illness: **Yes** ☐ **No** ☐
Please provide Name and phone number, if known:

19. In your opinion, what caused the workplace incident, accident or illness:

PLEASE CONTACT THE HR DEPT AT 705-324-6776, EXT. 22135, IF YOU ARE UNABLE TO RETURN TO WORK ON THE DAY FOLLOWING THE ACCIDENT OR IF YOU ARE UNABLE TO PERFORM YOUR REGULAR JOB DUTIES

I HAVE INFORMED AND PROVIDED MY PRINCIPAL / SUPERVISOR WITH A COPY OF THIS INCIDENT / ACCIDENT / ILLNESS REPORT
Please circle one: YES NO

AUTHORIZATION FOR THE COLLECTION OF THE INFORMATION ON THIS FORM IS IN KEEPING WITH THE FREEDOM OF INFORMATION LEGISLATION AND THE WSIB ACT AND REGULATIONS. THE INFORMATION MAY BE RELEASED TO SBCI CONTRACTED BY TLDSB FOR THE PURPOSE OF CLAIMS MANAGEMENT.

_____ _____ /_____/_____
Employee's Signature Date (dd/mm/yyyy)

Trillium Lakelands DISTRICT SCHOOL BOARD

PLEASE KEEP A COPY OF THIS REPORT FOR YOUR RECORDS Revised: January 17th, 2012

DEFINITION OF INCIDENT / ACCIDENT TYPE CODES

1. **INCIDENT** - An Incident is an unsafe act, an unsafe condition or a combination of both in the work environment which could have resulted in property loss and / or physical harm

2. **FIRST AID INJURY** - An injury of such minor nature that treatment can be carried out at the worksite.

3. **MEDICAL AID INJURY** - A work-related incident which requires treatment or a service outside of the workplace.

4. **LOST-TIME INJURY** - A work-related injury which results in time lost from work beyond the day of the injury.

5. **OCCUPATIONAL ILLNESS/ DISEASE** - An occupational illness/ disease is a health problem caused by exposure to a workplace health hazard.

6. **STRUCK OR CONTACT BY** - A struck or contact by incident is one in which a person has been contacted either abruptly and forcefully by some object in motion (e.g. box falls off shelf, employee jabs pin into finger, person pushing cart runs into person); or, has been contacted non forcefully by some substance or agent which has an injury-upon-contact characteristic, (e.g. employee is splashed by hot or corrosive solution).

7. **STRUCK AGAINST OR CONTACT WITH** - A struck against or contact with incident is one in which a person contacts either abruptly and forcefully some object in his surroundings, (e.g. teacher strikes leg against desk, person bumps head against cupboard door); or, comes into contact non-forcefully with some substance or agent capable of producing injury on the basis of mere non-forceful contact, (e.g. electrical shock, hot pipe, employee places hand in hot or corrosive solution).

8. **CAUGHT IN, UNDER, ON OR BETWEEN** - A caught in, under, on or between incident is one in which:
   a) a person is trapped in some type of enclosure, or a part of a person's body is caught fast in some type of opening, (e.g. a person is caught in an elevator, locked into a room, shut into a boiler)
   b) a person is caught under an object (e.g. a person has fingers caught under a window) window)
   c) a person or some part of their clothing is caught on some producing object (e.g. a person catches hand on sharp edge, catches loose clothing on a revolving spindle or some protruding object)
   d) a person is pinched, crushed or otherwise caught between either a moving object and a stationary object or between two or more moving objects (e.g. person jams fingers between wheeled cart and a doorway, person catches arm in an elevator door, jammed between a loaded moving cart and a wall).

9. **FALL** - A fall incident can be a foot level fall or a fall to below. A slip or trip would be recorded as a foot level fall. A foot level fall occurs when a person falls on the same level on which he was standing or walking, (e.g. person slips and falls to the floor). A fall to below occurs when a person falls to below the level on which he was standing or walking (e.g. person falls from ladder, window, chair or on the stairs).

10. **EXPOSURE** - An Exposure incident is one in which the employee is exposed to harmful conditions: i.e. a) toxic gases, fumes or vapours; b) contagious conditions; c) extremes of hot or cold; d) oxygen deficient atmospheres; e) radioactive radiation; f) intense light brightness.

11. **OVER EXERTION / STRAIN** - An over exertion / strain incident is one in which a person puts excessive strain on some part of their body or involves a repetitive body movement (e.g. employee strains back or some part of body lifting a student, equipment, supplies, etc..)

12. **STUDENT AGGRESSION / VIOLENCE** - A student aggression / violence incident is one in which the employee is subjected to an untoward action (or attempt of) by a student, (e.g. student bites, kicks, scratches, twists, strikes, verbal threats, etc.) to the employee.

13. **WORKPLACE VIOLENCE** - A workplace violence incident (not including student acts) are defined by the Occupational Health and Safety Act 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 a worker;
   c) A statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against a worker, in a workplace, that could cause physical injury to a worker.

14. **FIELD TRIP** - A field trip incident is one in which an employee is injured while on a school authorized field trip; is used in combination with another code (e.g. employee slips and falls on ice, when skating on a school trip, would record both Fall and Field Trip code)

wsib ONTARIO

Mail to: 200 Front Street West Toronto ON M5V 3J1

or Fax to: 416 344-4684 OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Claim No.

A. Section A to be completed by the employer and/or worker.

Worker's Last Name	First Name	Telephone

Address (no., street, apt.)	City/Town	Province	Postal Code

Employer's Name

Full Address (No., Street, Apt.)

City/Town | Prov. | Postal Code

Date of Birth (dd/mm/yyyy)

Date of Accident/ Awareness of Illness (dd/mm/yyyy)

Employer Telephone

Employer Fax No.

fold fold

1. Type of job at time of accident (where available, please attach description of job activities) | Area(s) of injury(ies)/illness(es)

2. Have the worker and the employer discussed Return To Work ☐ yes ☐ no | If no, will be discussed on dd mm yyyy

3. Employer contact name | Position

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature | Date dd mm yyyy

C. Health Professional's Billing Information
For billing purposes fax or mail pages 2 and 3 to the WSIB.

Health Professional's Designation

☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other _____

PROVIDER BILLING INFORMATION IN THE BOLDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

Are you registered with the WSIB? ☐ yes Please enter the **WSIB Provider ID.** in the box provided ▶ ☐ no Please call **1 - 800-569-7919** to register

WSIB Provider ID.

Your Invoice Number

Service Code **FAF**

▼ Complete these fields if **HST** is applicable to this form ▼

HST Registration Number	Service Code	HST Amount Billed
	ONHST	$.

Health Professional's Name (please print)

Address (No. Street, Apt.)

City/Town	Province	Postal Code	Fax

I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature	Telephone	Date dd mm yyyy

wsib ONTARIO

Mail to:
200 Front Street West
Toronto ON M5V 3J1

or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Worker's Last Name	First Name	Claim No.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment dd mm yyyy

2. Please check one:

- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

Travel to work:
- Ability to use public transit: ☐ yes ☐ no
- Ability to drive a car: ☐ yes ☐ no

2. Please indicate **Restrictions** that apply. Include additional details in section 3

- ☐ Bending/twisting repetitive movement of (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environmental exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s):

	Left	Right
Gripping	☐	☐
Pinching	☐	☐
Other (please specify)	☐	☐

- ☐ Limited pushing/pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify) Do not include names of medications.
- ☐ Exposure to vibration:
  - ☐ Whole body
  - ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions.**

4. From the date of this assessment, the above will apply for approximately:
☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ yes ☐ no

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours

Start Date dd mm yyyy

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions.** dd mm yyyy

I have provided this completed Functional Abilities Form to: ☐ **Worker** **and/or** ☐ **Employer**