



# ALGOMA DISTRICT SCHOOL BOARD HEALTH & SAFETY DEPARTMENT

644 ALBERT STREET EAST . SAULT STE. MARIE, ON . P6A 2K7  
(705) 945-7111 EXT. 10320 FAX (705) 945-7224

## ACCIDENT REPORT

Worker's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Position: \_\_\_\_\_

Workplace: \_\_\_\_\_

Will The Worker Be Absent From Work Due To The Accident?  No  Yes *(See Below)*

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Date Reported \_\_\_\_\_ Time Reported: \_\_\_\_\_

### Lost Time Only:

Last Day Worked was \_\_\_\_\_ Date Returned To Work: \_\_\_\_\_

Normal Work Hours: From \_\_\_\_\_ To \_\_\_\_\_ Normal Hours Worked Per Week: \_\_\_\_\_

What Happened To Cause The Injury? \_\_\_\_\_

What Part(s) Of The Body Were Injured ? *(ie Indicate Right or Left Side Also)* \_\_\_\_\_

What Type of Injury (sprain, bruising, laceration, etc.): \_\_\_\_\_

Who Was The Accident reported To ? *(ie. Principal, Supervisor, etc.)* \_\_\_\_\_

What Was The Worker Doing At The Time Of The Accident? (What Equipment or Materials Being Used, Give Size & Weights Of Objects Being Handled) : \_\_\_\_\_

Where Did Accident Occur ? *(ie. Classroom, Parking Lot, etc.)* \_\_\_\_\_

Were There Any Witnesses ? (Give Names): \_\_\_\_\_

Did Worker Seek Medical Treatment?  No  Yes Date Of Treatment: \_\_\_\_\_

Name and Address Of Health Professional: \_\_\_\_\_

Date when the Worker's Supervisor learned that the Worker received Medical Treatment? \_\_\_\_\_

Has Worker Had A previous Similar Injury? (If Yes, Explain Below)  No  Yes

Was Anyone Not Employed By The Board Involved In The Accident ?  No  Yes

If Yes, Explain :

Do You Have Any Reason To Doubt That The Injury Is Work Related ?  No  Yes

If Yes, Explain:

**ACCIDENT INVESTIGATION SECTION**

**Explain What Conditions Contributed Most Directly To This Accident**

**Explain The reasons For The Existence Of These Conditions**

**What Steps Have You Taken As Supervisor To Prevent A Recurrence ? (Explain When You Did This Or Date When It Will Be Completed)**

Principal / Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE NOTE:**

**Please FAX forms to the Health & Safety Office & then send originals in courier.** FAX number is (705) 945-7224. The Board has only 3 days from date you were informed to report the accident without a penalty. If the injury is by definition a **"critical injury"** (see Health & Safety Manual Document 03-01-2 and 03-01-03) follow the outlined procedure or call the Health and Safety Office at (705) 945-7111 ext. 10320 for further information.