The Town of Fort Frances	**SECTION** HEALTH AND SAFETY
ACCIDENT / INCIDENT REPORTING POLICY	**REVISED** May 2004
Resolution No.	Supercedes Resolution No.
Policy Number 5.20	**PAGE 1 of 3**

1. PURPOSE:

To provide a procedure which outlines the reporting requirements for all accidents / incidents and injuries requiring health care.

2. RESPONSIBILITY:

1. Employees are required to report all accidents and incidents (non-medical / near misses and injuries requiring medical attention) to their immediate supervisor and to keep him / her advised of their return to work status (if required).

2. The supervisor is responsible for notifying the Human Resources Manager of any accidents / incidents and for updating him / her on changes to an employee's return to work status (if required).

3. The Human Resources Manager is responsible for the completion and forwarding of the claim to the Workplace Safety and Insurance Board (WSIB).

3. PROCEDURE:

A. Initial Claim:

1. Within 24 hours of an accident / incident, the supervisor shall forward a completed, signed copy of the **"Employee Incident Report"** to the Human Resources Manager.

2. If health care is required, the Human Resources Manager will complete the WSIB Form 7, submit it to WSIB, distribute a copy to the employee and place a copy in the employee's personnel file.

B. Subsequent Claim:

1. If the employee should require further health care contact with a health care practitioner (a doctor, skilled nurse, chiropractor, physiotherapist, etc.), miss any time at work, or require modifications in your job from this workplace injury, the employee shall notify the direct supervisor and the supervisor shall notify the Human Resources Manager immediately with this information.

2. The employee will have a **"Functional Ability Form"** completed with every visit to the attending health provider. This form can be found at www.wsib.on.ca.

3. This will be given to the supervisor, who will then forward a copy to the Human Resources Manager.

4. The supervisor, Human Resources Manager, and employee will fully cooperate with the development of modified duties and / or an employee's return to work.

THE TOWN OF FORT FRANCES
FORT FRANCES, ONTARIO
CANADA

EMPLOYEE INCIDENT REPORT

Note: FAX this form to the Human Resources Department at 274-8479 on the same day as the incident occurred and prior to seeking medical attention other than in an emergency situation. Questions: Please call Christine Ruppenstein at 274-3436 ext.279

Employee Information

Last Name	Birth Date
First Name	Telephone Number
Address	Department
SIN	Job Title

Details of Injury

Date of Injury (D/M/Y)	Time of Injury (AM/PM)	Date and Hour Reported To Employer
Where did the accident occur?		
Who was the injury / accident reported to?		
What happened to cause the injury?		
Explain what the worker was doing and the effort involved.		
Identify the size, weight and type of equipment or materials involved.		
Describe the injury, part of body involved and specify left or right side.		
Names of witnesses or persons having knowledge of the injury / incident.		

Health Care

Did the Worker receive health care?	Yes ( )	No ( )	Don't Know ( )
Name and Address of Attending Physician			
Lost Time?	Yes ( )	No ( )	Don't Know ( )

Other

Was the site of the accident visited?	By whom?
Conditions contributed to accident and the steps taken to prevent recurrence:	
Person insuring that the above steps are taken:	
When will this action be done?	

Claim Information

To your knowledge, has the employee had a previous or similar disability? Yes ( ) No ( )	
Comments:	
Supervisor's Signature:	Date
Employee Signature:	Date