ACCIDENT REPORTING INSTRUCTIONS

FOR NON-TEACHING STAFF

The accident reporting package contains all the necessary paperwork you will need to complete for your injury as well as important information for your health care provider and therefore it is necessary to have the package in hand, prior to leaving the workplace to seek medical treatment.

This package contains the following paperwork:

- MSBA - Employee Accident Report
- WCB Green Card
- WCB Workers Accident Report
- Occupational Health Assessment Form

What paperwork is required to be completed and when must it be handed in?

- For every accident/incident – the worker is required to complete the following at the time of the incident: (injuries can include: whiplash, bruising, pulled muscles, sprains, crush, punch, kick, fall, etc.)
  - **MSBA Employee Accident Report –** completes the paper copy and return to the admin office the same day. The school secretary will complete the on-line form.
  - **WCB Green Card –** complete the paper copy, keep the yellow copy and return the green copy to the admin office the same day.
  - **Violent Incident Report –** completed by the worker on-line when a violent incident has occurred.

- For work related injuries requiring medical care:
  - **WCB Workers Accident Report** - You (the worker) must complete the WCB Workers Accident Report and return it to the school office as soon as you know you will be seeing a health care provider for your injury or the next day after your appointment but no later.

  - **Occupational Health Assessment Form** – Please have your health care provider complete the Occupational Health Assessment Form (OHAF) if you have an injury that may prevent you from being able to perform your full duties while at work. This form indicates what your functional capabilities (accommodations/restrictions) are, due to the incident, and allows the division to determine modified/alternate or light duties to safely accommodate you at work. The form must be completed in full and indicate what your functional capabilities are, the duration for the restrictions, and a date for the next assessment. You may be required to have this form completed whenever your functional capabilities change. You are required to return this from to the school office or supervisor the same day or next day after visiting the doctor but no later. **Note:** Question #3 on the form cannot be left blank.

  - **Note:** All non-teaching employees filing a WCB claim must have reported their accident to their supervisor; completed and returned the appropriate paperwork to their supervisor in a timely fashion (next day) to ensure that their claims will be initiated and that they are appropriately paid. Failure to do so may cause your claim to be denied, suspended or terminated by WCB.

- If you or your family is having difficulty dealing with the effects on an injury please call the ***WCB Distress Line***. Trained counsellors from the Klinic Community Health Centre are available 24/7. The service is free of charge. **Phone #204-786-8175**

All paperwork is required to be delivered to the school office and then forwarded to the Divisional Safety Officer

MANITOBA School Boards ASSOCIATION

EMPLOYEE ACCIDENT/INCIDENT REPORT

All Fields are required to be completed.

Please Select Your School Division & Location:

School Board: Pembina Trails School Division

School Name:

Phone #: 204 -

First name of injured person:

Last name of injured person:

Job title of injured person:

Date of birth: Month: Day: Year:

Address:

City/Province:

Postal Code:

Telephone #: 204 -

Date of accident: Month: Day: Year:

Time of accident: Hour: Minute: AM / PM

Where did the accident occur? If other, please specify.

IA Class Home Ec. Class Classroom Laboratory Playground Field Trip Bus
Phys. Ed. – Outside Phys. Ed. – Inside Other: _____

Describe in detail how accident occurred:

MANITOBA School Boards ASSOCIATION

EMPLOYEE ACCIDENT/INCIDENT REPORT

Guidelines on classification of accident/injuries (Check One):

- "MINOR" - Scratch, Bruise, Scrape, Minor Cut, Minor Sprain, etc.
- "MODERATE" - Serious Cut, More Severe Sprain, Broken Finger, etc.
- "SEVERE" - Injury to Eye, Face, Back, Broken Arm/Leg, etc.
- "NEAR MISS"

Exact nature and type of injury: Circle all that apply. If other, please specify.

Nature of injury: cut break crush poke burn hit fall concussion amputation

other:_____

Type of injury (Body Part): arm leg head/face chest hip back (upper/lower) hand foot

finger toe other: _____

Where on the body: left right Not applicable

Was injury treated (circle one): Yes No Not Known Other:_____

Additional comments:
(type of treatment)

Name of witness(es):

1.
2.
3.

Any additional comments:
(Details of hospital, x-ray, etc.)

Name of principal/supervisor
(in full):

Submitted by:

Email:

Date Submitted: Day: Month: Year:

THE INFORMATION THAT YOU SUPPLY ON THIS FORM WILL BE USED SOLELY FOR THE PURPOSE OF CLAIM INVESTIGATION.

WCB Workers Compensation Board of Manitoba

Phone 204-954-4321
(Toll free 1-855-954-4321)
333 Broadway, Winnipeg R3C 4W3
wcb.mb.ca

Worker Incident Report

Claim Number	3

Worker Information (Please type all dates as DD-MM-YYYY.)

Last Name		First Name	
Address		City	Province
Postal Code	Phone Number	Email	
Date of Birth (DD-MM-YYYY)		PHIN	
Social Insurance Number	Gender	Job Title	

Employer Information

Business Name		Address (include branch where applicable)	
City	Province	Postal Code	Phone Number

Injury Details

Date of incident (DD-MM-YYYY)	Area(s) of injury
Date reported to employer (DD-MM-YYYY)	Name and position to whom incident was reported

Please describe the incident in as much detail as possible. (Use seperate sheet if necessary. If applicable, identify any witnesses.)

City and province where incident occured

Did the incident occur on your employer's premises? ☐ Yes ☐ No	If no, specify name and address of premises where incident happened.

Name and Address of Doctor(s) and/or Hospital(s) that Provided Treatment (Attach separate sheet if necessary.)

Name	Address	Date of Visit (DD-MM-YYYY)

Time Loss and Wages (Only complete this section if you have missed time from work beyond the date of the incident.)

What was the last day and hour you worked following the incident?_____(DD/MM/YYYY) at _____ _____ Hour ☐ AM ☐ PM

Have you returned to work? ☐ Yes ☐ No If yes, when? _____(DD/MM/YYYY) at _____ _____ Hour ☐ AM ☐ PM

Were you paid wages by your employer while you were off work? ☐ Yes ☐ No	Do you have other sources of employment income? ☐ Yes ☐ No
How many hours do you work per week? If it varies, please describe.	What are your regular days off? If it varies, please describe.
What is your current hourly wage? $	What are your regular gross earnings? (Specify weekly, bi-weekly, etc.) $
What is your marital status? ☐Single ☐Common-law ☐Married ☐Separated ☐Divorced	If married/common-law, is your spouse/partner working? ☐ Yes ☐ No

Fax this form - in Winnipeg: 204-954-4999 | toll free: 1-877-872-3804

For faster claim reporting, please call 204-954-4100 | Toll free 1-855-954-4321

Worker's Name	Claim Number	3

Time Loss and Wages (Continued)

Are you personally allowed to claim a deduction on your current year Income Tax Return for:		
Dependant children age 18 years or younger? ☐ Yes ☐ No	If yes, how many dependants?	
Disabled dependants age 18 years or older? ☐ Yes ☐ No	If yes, how many dependants?	
Child care expenses? ☐ Yes ☐ No	If yes, estimate total deduction for current tax year. $	
Child support payments? ☐ Yes ☐ No	If yes, state monthly amount. $	Total for the year $
Spousal support payments? ☐ Yes ☐ No	If yes, state monthly amount. $	Total for the year $
Have you applied for income from other sources? (e.g. EI, CPP, Social Insurance, Company Disability Plan, etc.) ☐ Yes ☐ No	If yes, please describe.	

Coverage

Was anyone not employed by your employer involved in the incident? ☐ Yes ☐ No	If yes, give name and address.	
Are you a partner, director or sole proprietor of the company? ☐ Yes ☐ No		
Are you a sub-contractor? ☐ Yes ☐ No	If yes, specify: ☐ Construction ☐ Logging	(Complete appropriate sections below.)
Are you an owner operator? ☐ Yes ☐ No	If yes, specify: ☐ Courier ☐ Trucking ☐ Towing	(Complete appropriate sections below.)

Please answer these questions if the incident occured between Jan. 1, 1992 and Dec. 31, 2005.

Are you a member of the family of your employer (or if the employer is a corporation, a family member of a director of the corporation)? ☐ Yes ☐ No

If yes, at the time of the incident did you reside with the employer or director? ☐ Yes ☐ No

Farming

Are you related to the farm owner? ☐ Yes ☐ No

Sub-Contractor or Owner Operator (Only complete if you are a sub-contractor or owner operator.)

Is your employer covering you under their WCB coverage? ☐ Yes ☐ No	If no, are you registered with WCB? ☐ Yes ☐ No
Do you work in a partnership? ☐ Yes ☐ No	Do you employ other workers? ☐ Yes ☐ No

Sub-Contractor in Construction

Do you supply any materials or equipment? ☐ Yes ☐ No	If yes, please specify.

Sub-Contractor in Logging

Do you supply any materials or equipment? ☐ Yes ☐ No	If yes, please specify.
Were you cutting on the firm's timber sale, timber permit or sawmill license? ☐ Yes ☐ No	If no, on whose timber sale, timber permit or sawmill license were you cutting?

Owner Operator is a Courier

What is the gross vehicle weight? (This can be obtained from the Autopac registration.)

Owner Operator in Trucking

Do you haul within a 16 km radius of the city or town in which the home terminal is located? ☐ Yes ☐ No	Are you a long distance driver? ☐ Yes ☐ No
Do you provide a vehicle? ☐ Yes ☐ No If yes, how many vehicles do you provide?	

I understand that under *The Workers Compensation Act* the WCB can collect information about me to adjudicate and manage my claim and that information from my claim may be disclosed to my employer or employer representative for WCB program purposes, or may be released to others as authorized by legislation, including *The Workers Compensation Act, The Personal Health Information Act* and *The Freedom of Information* and *Protection of Privacy Act*. The information collected may be used to conduct WCB evaluations and surveys.

If you have any questions regarding the collection, use or disclosure of information on your claim, please contact the WCB's Access and Privacy Officer at (204) 954-4557 or toll free at 1-855-954-4321 extension 4557. If you have any other questions regarding your claim, please call the Claims Service Centre at (204) 954-4321 or toll free at 1-855-954-4321.

Note: The information on this form is collected under the authority of sections 36(1) of *The Freedom of Information and Protection of Privacy Act*, 13(1) of *The Personal Health Information Act and The Workers Compensation Act*.

Release for Medical Information

I authorize persons in possession of medical and other information that the WCB determines relevant to this claim to release same to the WCB upon request.

Release for Income Information from Canada Revenue Agency

This is your authorization to provide the Workers Compensation Board of Manitoba with copies of my complete income tax returns and other taxpayer information including all supporting information slips, schedules and financial statements. The information will be used:

(1) to assist in establishing my net average earnings and

(2) to determine and verify eligibility for benefits under The Workers Compensation Act.

This authorization is valid for the two taxation years prior to the year it was signed, the year it was signed, and each following taxation year where benefits are provided.

Signature of the Worker	Date (DD/MM/YYYY)
X	

OCCUPATIONAL HEALTH ASSESSMENT FORM

TO ALL EMPLOYEES:
Please return this completed form to your supervisor within 24 hours of being away from work due to accident or illness, and/or prior to the start of your next scheduled shift.

AUTHORIZATION TO RELEASE INFORMATION

I understand that modified or alternate duties are available at Pembina Trails School Division to assist with my return to work. I authorize my doctor, to release information to Pembina Trails School Division concerning my functional capabilities and/or limitations and restrictions. I give permission for Human Resources to contact my Health Care Provider to discuss or clarify information obtained on this form and /or return to work.

Employee Name (please print)	Employee Signature	Date (mm/dd/yyyy)

ATTENDING PHYSICIAN (Please complete in full, including restrictions & capabilities section):
Please ensure the above authorization is signed before completing the following information. This will assist Pembina Trails School Division in providing the earliest, safest, meaningful, and productive return to work possible for this employee.

1. On the basis of my examination on _____, 20____, this employee:
   a) is able to return to regular work duties? □ Yes □ No
   b) is able to work normal scheduled hours? □ Yes □ No Reduced Hours Please Specify: _____

2. Indicate the location of the injury:
   □ Head (incl. vision, hearing, speech) □ Systemic or non-physical □ Neck □ Chest □ Abdomen □ Back (upper / lower) □ Knee or lower leg (L or R)
   □ Ankle or Foot (L or R) □ Hip or upper leg (L or R) □ Shoulder / upper arm (L or R) □ Elbow / lower arm (L or R) □ Wrist / Hand (L or R)

3. Indicate Functional Capabilities (Complete in full)
   lifting □ Unable □ Limited: Specify: _____ carrying □ Unable □ Limited: Specify: _____
   push/pull □ Unable □ Limited: Specify: _____ sitting □ Unable □ Limited: Specify: _____
   standing □ Unable □ Limited: Specify: _____ walking □ Unable □ Limited: Specify: _____
   squatting □ Unable □ Limited: Specify: _____ reaching □ Unable □ Limited: Specify: _____
   bend/twist □ Unable □ Limited: Specify: _____ work above shoulder □ Unable □ Limited: Specify: _____
   repetitive work □ Unable □ Limited: Specify: _____
   Indicate any other limitations/restrictions (concentration, judgment, maintaining stamina, etc.)_____
   _____

4. Is the individual taking medication that may affect their ability to work? □Yes □No Specify limitations: _____
5. Duration of Restrictions: _____
6. Are the limitations considered permanent? □Yes □No In what period can recovery be anticipated? _____
7. Prognosis:_____
8. This employee will be reassessed on: _____
9. Comments:_____
   _____

Providers Name & Address (please print) _____

Signature: _____ Date:_____Phone Number:_____

RETURN TO WORK PLAN

This RETURN TO WORK PLAN has been developed by the employee, Supervisor, and Safety Officer exclusively for _____, and takes into account all of the functional capabilities identified by the health care provider on the Occupational Health Assessment Form (reverse side).

WORK WEEK (DATE)	DAYS/HOURS SCHEDULED EACH WEEK							COMMENTS
	MON	TUES	WED	THUR	FRI	SAT	SUN	

Additional Comments:_____
_____
_____

Expectations/Special Instructions

This plan will guide you in returning to your regular job activities by gradually increasing your duties as you recover from your injury.

- ☐ Check in regularly (**at the end of each day**) with your supervisor to let them know how you are progressing on the return to work plan.
- ☐ **Immediately contact your Supervisor if** you are not progressing as per your RTW plan or if you have any concerns or are asked to perform duties NOT included in this plan.

We agree to abide by this plan in an effort to succeed with a safe and fair return to work. Each party has an obligation to advise the others of any circumstances that might affect the plan. Changes to this agreement must meet the approval of all original parties.

_____ , _____, _____
EMPLOYEE SUPERVISOR DATE

OR

I have discussed the above plan with my supervisor and the Safety & Health Officer and am refusing to participate at this time.

_____, _____, _____
EMPLOYEE SUPERVISOR DATE

NOTICE OF INJURY TO EMPLOYER

WCB Workers Compensation Board of Manitoba
wcb.mb.ca

IMPORTANT: Do not send this form to the WCB. Keep one copy for yourself and provide a copy to your employer.

If the workplace incident has resulted in an injury requiring healthcare attention or time off from work, please report the injury to the WCB by calling:

204-954-4321 or toll free 1-855-954-4321 (8:00 AM to 7:00 PM, Monday to Friday)

Injured Worker Name _____

Injured Worker Address _____

Date of Injury _____ Time _____ ☐AM ☐PM

Location of Incident (site address and location on site)

_____

Description of Incident

_____

_____

Description of Injury

_____

_____

Time Off Work Due to Injury ☐Yes ☐No

Names of Witnesses (if any) _____

Supervisor Signature _____

Injured Worker Signature _____

Date _____