

ACCIDENT REPORTING INSTRUCTIONS

TEACHING STAFF/CONSULTANTS

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/Incident Report
- Occupational Health Assessment Form

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

- Every accident/incident – the teacher is required to complete the following at the time of the incident:
 - **MSBA Employee Accident/Incident Report** – complete the paper copy and return to the admin office the same day.
- If you will be seeing a health care provider or missing work due to a work related injury, please complete the following:
 - **Occupational Health Assessment Form** – your health care provider is required to complete this form 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 form 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:** If your restrictions can not be accommodated you may be temporarily re-assigned until you have recovered and are capable of returning to your original position. The Division will attempt to accommodate teachers/consultants; however accommodation will depend on the extent of the restrictions.

The occupational Health Assessment Form must be returned to your supervisor the day of treatment or the following day after treatment but no later.

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

EMPLOYEE ACCIDENT/INCIDENT REPORT

All Fields are required to be completed.

Please Select Your School Division & Location:			
School Board:	<input type="text" value="Pembina Trails School Division"/>		
School Name:	<input type="text"/>		
Phone #:	<input type="text" value="204 -"/>		
First name of injured person:	<input type="text"/>		
Last name of injured person:	<input type="text"/>		
Job title of injured person:	<input type="text"/>		
Date of birth:	Month:	Day:	Year:
<input type="text"/>			
Address:	<input type="text"/>		
City/Province:	<input type="text"/>		
Postal Code:	<input type="text"/>		
Telephone #:	<input type="text" value="204 -"/>		
Date of accident:	Month:	Day:	Year:
<input type="text"/>			
Time of accident:	Hour:	Minute:	AM / PM
<input type="text"/>			
Where did the accident occur? If other, please specify.			
<input type="text" value="IA Class"/> <input type="text" value="Home Ec. Class"/> <input type="text" value="Classroom"/> <input type="text" value="Laboratory"/> <input type="text" value="Playground"/> <input type="text" value="Field Trip"/> <input type="text" value="Bus"/> <input type="text" value="Phys. Ed. – Outside"/> <input type="text" value="Phys. Ed. – Inside"/> <input type="text" value="Other: _____"/>			
Describe in detail how accident occurred:			
<input type="text"/>			

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:

