

This package contains the following paperwork:

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.

	MSBA Employee Accident/Incident Report Occupational Health Assessment Form
Wh	at 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 <u>functional capabilities are</u>, 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: If your restrictions can not be accommodated you may be temporarily reassigned 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: Pembina Trails School Division						
School Name:						
Phone #: 204 -						
First name of injured person:						
Last name of injure	ed person:					
Job title of injured	person:					
Date of birth:	Month: Day: Year:					
Address:						
City/Province:						
Postal Code:						
Telephone #: 2	04 -					
Date of accident:	Month: Day: Year:					
Time of accident:	Hour: AM / PM					
Where did the acci	dent 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:						



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 other:	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:				



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
dod	nderstand that modified or alternate duties are available at Pembina Trails School Division to assist with my return to work. I authorize my ctor, to release information to Pembina Trails School Division concerning my functional capabilities and/or limitations and restrictions. I give mission for Human Resources to contact my Health Care Provider to discuss or clarify information obtained on this form and /or return to rk.
	Employee Name (please print) Employee Signature Date (mm/dd/yyyy)
Ple	TENDING PHYSICIAN (Please complete in full, including restrictions & capabilities section): ease ensure the above authorization is signed before completing the following information. This will assist Pembina Trails School Division in eviding 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 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) Indicate Functional Capabilities (Complete in full) Iifting Unable Limited: Specify:
4.	Is the individual taking medication that may affect their ability to work?
5.	Duration of Restrictions:
6.	Are the limitations considered permanent?
7.	Prognosis:
8.	This employee will be reassessed on:
9.	Comments:
Pro	viders Name & Address (please print)

Signature:

Date:

Phone Number:



RETURN TO WORK PLAN

on the Occupation		, and	takes into	account a	all of the			nd Safety Officer exclusively for ties identified by the health care provider
·			,		,			
WORK WEE (DATE)		AYS/HO				CH WE	EK SUN	COMMENTS
(DATE)	MON	TOLO	WLD	THOIL	I IXI	JAI	JON	
Additional Commer	nts:							
Expectations/	•							
								duties as you recover from your injury. but are progressing on the return to work plan.
☐ Immediately c	ontact your	Superviso	r if you a	re not progr	essing as	per your l	RTW plan	or if you have any concerns or are asked to
perform duties	NOT include	d in this pla	n.					
•	,							party has an obligation to advise the others of val of all original parties.
arry or our rotation	that might ar	root trio piai	i. Onange	o to tino ag	roomone	muot moot	тто аррго	val of all original partico.
EMPLOYEE			,	S	SUPERVISOR	?		DATE
I have discussed th	e above plar	n with my su	pervisor a	OR and the Safe	ety & Hea	alth Officer	and am re	efusing to participate at this time.
	·	•			-			
EMPLOYEE			,	S	SUPERVISOR	?	,	DATE