APPENDIX E (AP 5-2)

District School Board of Niagara

CO-OP STUDENT ACCIDENT REPORT

INSTRUCTIONS TO CO-OP TEACHER AND STUDENT:

- ✔ Complete form and sign & date below.
- ✔ Make sure your Principal/Supervisor gets a copy of this report
- ✔ FAX this report with copy of **WORK EDUCATION AGREEMENT**
- ✔ **FAX TO: Disability Management Co-ordinator, Human Resources, within 24hours of the accident - 905-641-9223**

STUDENT NAME: ____________________ **HOME PHONE NUMBER:** ____________________

ADDRESS: ____________________ **STUDENT'S SCHOOL:** ____________________

SOCIAL INSURANCE NO. ____________________ **DATE OF BIRTH:** ____________________

ACCIDENT LOCATION: ____________________ **JOB TITLE/POSITION:** ____________________

WORKING HOURS: FROM__________ **TO** __________ **DAYS WORKED PER WEEK** ____________________

Date & Time of Accident/Illness: Date ____________________ **Time:**____________________

Date & Time Reported: Date ____________________ **Time:** ____________________

Reported to: (Name and Position) ____________________

TYPE OF ACCIDENT/ILLNESS (Please check all that apply):

❍ Struck/Caught ❍ Fall ❍ Slip/Trip
❍ Overexertion ❍ Harmful Substances/Environment ❍ Motor Vehicle Accident
❍ Repetition ❍ Assault ❍ Fire/Explosion
❍ Other ____________________

WAS ACCIDENT/ILLNESS:

❍ Sudden Specific Event/Occurrence ❍ Gradually Occurring Over time
❍ Occupational Disease ❍ Fatality

AREA OF INJURY (BODY PART) (Please check all that apply):

❍ Head ❍ Face ❍ Eye(s) ❍ Ear(s) ❍ Teeth ❍ Neck ❍ Chest ❍ Upper Back
❍ Lower Back ❍ Abdomen ❍ Pelvis ❍Other ____________________

PLEASE INDICATE LEFT OR RIGHT:

Shoulder	❍ Left	❍ Right	Arm	❍ Left	❍ Right	Elbow	❍ Left	❍ Right
Forearm	❍ Left	❍ Right	Wrist	❍ Left	❍ Right	Hand	❍ Left	❍ Right
Finger(s)	❍ Left	❍ Right	Hip	❍ Left	❍ Right	Thigh	❍ Left	❍ Right
Knee	❍ Left	❍ Right	Lower Leg	❍ Left	❍ Right	Ankle	❍ Left	❍ Right
Foot	❍ Left	❍ Right	Toe(s)	❍ Left	❍ Right			

DESCRIBE what happened to cause accident/illness and what the worker was doing at the time. What the injury is and any details of equipment, materials, environment conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have been involved **OR** a condition that occurred gradually over time:

WHAT HAPPENED: ____________________

WHAT WAS WORKER DOING: ____________________

____

WHAT WAS THE INJURY/ILLNESS (strain/cut/etc.): ____________________

EQUIPMENT USED/ENVIRONMENT CONDITIONS:____________________

____

WITNESSES: ____________________ ____________________

COMPLETE PAGE 2 ☞

Are you aware of any prior similar/related problem, injury of condition? ❍ Yes ❍ No
If **yes**, please explain ____

Do you have any prior related WSIB/WCB claims? ❍ No ❍ Yes - in Ontario ❍ Yes - outside Ontario

When did you first have problems with this injury/condition? ______________________________

If you did not report this to your CO-OP employer and your CO-OP teacher right away, please tell us why:
____

____

****

HEALTH CARE:
Did you receive health care for this injury? ❍ Yes ❍ No When: ____________________

When did DSBN learn that you received health care? ______________________________

Where were you treated for this injury? (Check all that apply)

❍ On-site health care ❍ Ambulance ❍ Emergency Dept. ❍ Admitted to Hospital ❍ Clinic

❍ Health Professional Office (Doctor/Dentist/Chiropractor/Physiotherapist)

Name, Address and Phone number of health professional (if known) ________________________

____

Were you prescribed medications/drugs? ❍ Yes ❍ No

Were you referred for any other treatment or tests? ❍ Yes ❍ No

Did you talk to your health care professional about returning to modified/regular work? ❍ Yes ❍ No
****

LOST TIME - NO LOST TIME

Please choose ONE - **After day of accident/awareness of illness, did you:**

❍ Return to **regular job** and **NOT** lose any time and/or earnings
❍ Return to **modified** job and **NOT** los any time and/or earnings
❍ **Lose** time and/or earnings - complete below

First day of lost time ______________ Date back to Work ________________ Regular/Modified?

DECLARATIONS AND SIGNATURE:
By signing below, you are claiming benefits (either health care or health care and lost time) under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. When you make a claim for benefits, you must consent to disclose your functional abilities information. Your consent allows your health care practitioner to release information about your functional abilities directly to your employer in addition to the WSIB.

It is an offense to deliberately make false statements to the Workplace Safety and Insurance Board.
I declare that all of the information provided on pages 1 and 2 is true.

______________________________ ______________________________

CO-OP STUDENT'S SIGNATURE **DATE**

______________________________ ______________________________

CO-OP TEACHER'S SIGNATURE **CO-OP STUDENT'S PRINCIPAL'S SIGNATURE**

ONCE SIGNED, PLEASE FAX WITH COPY OF WORK EDUCATION AGREEMENT FORM WTHIN 24 HOURS OF INCIDENT TO 905- 641-9223