Waterloo Catholic District School Board

UNPAID WORK PLACEMENT
INCIDENT REPORT FORM

IT IS YOUR (EMPLOYEE'S) RESPONSIBILITY TO SEND THIS FORM WITHIN 24 HOURS OF THE ACCIDENT TO HUMAN RESOURCE SERVICES

EMAIL: wcdsb.safety@wcdsb.ca

FAX: 519-578-2818

☐ Injury

☐ First Aid

☐ Health Care

☐ No Injury

Hazardous Situation

WORKER INFORMATION

Last Name:	**First Name:**	**Sex:** ☐ M ☐ F
City/Town:	**Province:**	**Postal Code:**
Telephone:	**Alternate Telephone:**	
Name of College or University:		
Start Date:	**Hours Per Day:** **Start Time:** **End Time:**	
Work Site:	**Position:**	

INCIDENT INFORMATION

Date of Incident:	**Time of Incident:** ☐ AM ☐ PM

Description of Incident:

☐ continued on back/attached

Type of Incident

☐ Aggression ☐ Over Exertion
☐ Repetitive Strain ☐ Sharps
☐ Slip, Trip or Fall ☐ Struck by/Against Object
☐ Other_____

If this was a Slip, Trip or Fall describe footwear:

Witnesses to the incident: (Do not include student names)

Location of Incident: (School / Location Name) Room Number:

Inside: ☐ Entrance ☐ Classroom ☐ Hallway ☐ Stairwell ☐ Office ☐ Washroom ☐ Other_____

Outside: ☐ Entrance ☐ In Vehicle ☐ Parking Lot ☐ Stairs ☐ Playground ☐ Walkway ☐ Other_____

What was the injury?: ☐ Bite ☐ Bruise/Contusion ☐ Cut/Laceration ☐ Dizziness ☐ Muscle Ache ☐ Sprain/Strain ☐ Swelling ☐ Other_____

Indicate what part of the body, Right (**R**), Left (**L**) or both (**B**) that were injured.

☐ Head ____	☐ Teeth ____	☐ Pelvis ____	☐ Elbow____	☐ Upper Back____	☐ Upper Leg____
☐ Face ____	☐ Neck ____	☐ Shoulder ____	☐ Wrist____	☐ Lower Back____	☐ Lower Leg____
☐ Eye ____	☐ Abdomen ___	☐ Upper Arm ___	☐ Hand____	☐ Hip ____	☐ Ankle ____
☐ Ear ____	☐ Chest ____	☐ Lower Arm ____	☐ Finger(s)____	☐ Knee____	☐ Feet ____
					☐ Toe(s) ____

THE ABOVE INFORMATION IS TO BE USED FOR COMPLETION OF WSIB FORM # 7 AND/OR INVESTIGATION BY HEALTH AND SAFETY

Waterloo Catholic District School Board

UNPAID WORK PLACEMENT
INCIDENT REPORT FORM

MEDICAL INFORMATION (IF APPLICABLE)	
Did you see a medical professional? ☐ Yes ☐ No If **YES:** Name of Medical Professional_____ Date of Medical Treatment_____	**Treatment of Injury** ☐ Family Physician ☐ Chiropractor ☐ Emergency Room ☐ Physiotherapy ☐ Walk-In Clinic ☐ Massage ☐ First Aid Station ☐ Other _____
**** If you did seek medical attention, please fax Page 3 of the Health Professional Report (Form 8) to 519-578-2818 ****	
Did you finish your scheduled shift? ☐ Yes ☐ No If **NO**, what time did you leave work? _____ **Will you be absent from work the day after the accident?** ☐ Yes ☐ No ☐ Not Sure	
****If you are going to be absent from work due to this incident, please call 519-578-3660 ext. 2315****	
SIGNATURES	
Employee Signature	**Date**
Principal/Supervisor Signature	**I acknowledge this accident occurred and I have taken precautions in an attempt to avoid further accidents/injuries.**

THE ABOVE INFORMATION IS TO BE USED FOR COMPLETION OF WSIB FORM # 7 AND/OR INVESTIGATION BY HEALTH AND SAFETY