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 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 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

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:

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.

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

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

Where: left right

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

other: _____

Was injury treated (circle one):	Yes No Not Known Other:
If treated, by whom?	
If treated, type of treatment:	
Name of witness(es):	1. 2. 3.
Any additional comments: (details of hospital, x-ray, etc.)	
Name of principal(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.

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:_____

IT IS THE RESPONSIBILITY OF THE EMPLOYEE TO RETURN THIS FORM TO THEIR SUPERVISOR. PLEASE FORWARD THE ORIGINAL TO THE SAFETY OFFICER

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

IT IS THE RESPONSIBILITY OF THE EMPLOYEE TO RETURN THIS FORM TO THEIR SUPERVISOR. PLEASE FORWARD THE ORIGINAL TO THE SAFETY OFFICER