EIR (Employee Incident Report)

Instructions for completing the form

August 2017

If the incident involves aggression/violence, complete form EIR-A instead

Complete and submit the following within 48 business hours to the Health and Safety Department:

- Scan and send to **eir@hdsb.ca** **or fax to 905-319-0440**

Hazard Only (*A hazardous situation, near miss or a bodily contact that may or may not cause injury)*

Example:

- Employee was getting textbooks down from a shelf and the shelf fell but just missed hitting her head.

First Aid (*A minor injury was sustained that required attention by a Certified First Aider **or** was self-administered/monitored)*

Examples:

- Employee was struck in the head by a soccer ball during supervision duty on the playground and applied ice to the area.
- Employee slipped on wet floor and twisted her ankle; a first aider examined her ankle for signs of swelling.

Health Care (*Employee sought medical attention which includes an MD, Chiropractor, Physiotherapist, Dentist, Hospital Emergency, etc.)*

Example:

- Employee cut her finger while using the paper cutter and went to the Hospital Emergency Department for stitches.

Lost Time (*Time lost is any time **following the day of injury** (absence on the day of injury is not Lost Time).*

Example:

- Employee injured her knee after slipping and falling on ice covered blacktop in the parking lot. She was absent for 2 days.

General Instructions:

- If you don't have computer access and are writing information – do not use light coloured ink pens or light pencil.
- Complete the form as thoroughly as possible to avoid follow-up questions.
- Do not submit multiple copies of an EIR – you can request an email confirmation if you need to be sure that we received it.
- This form is meant to report incidents that **involves the employee. It can be completed by the employee or the employee's supervisor.**
- Do not provide full name of a student - only use initials to identify students for confidentiality.
- If an employee is absent from work and/or unable to complete the EIR, the supervisor must complete the form and contact the employee to collect information regarding the incident. Do not wait for the employee to return to work in order to complete the form.

Special Notes:

Section 3:

- Indicate the Classification of the incident – read the definition before choosing the appropriate one.
- If there is a change (i.e. the report was submitted as First Aid and employee went to the doctor later), inform your Principal/VP/Manager/Supervisor immediately and they will notify the Health and Safety Dept. with an email and/or a revised EIR.

Section 4:

- The Ministry of Labour requires that all incidents be investigated and that any corrective actions/preventative measures taken be reported.
- This section is completed by the employee's supervisor after they investigate the incident.

Signatures:

- The Principal/VP/Manager/Supervisor must sign and date if the EIR is not sent directly from their email.
- The employee's signature is to indicate that they have received a copy of the report – it is not necessary to wait for this signature before submitting to the Health and Safety Department.

EIR (Employee Incident Report)

"**Critical Injury**" means an injury of a serious nature which: places a life in jeopardy, produces unconsciousness, results in substantial loss of blood, causes the loss of sight in an eye, involves fracture or amputation of a leg, arm, hand or foot (not a finger or toe) or consists of burns to a major portion of the body. **IMPORTANT**: Call Health & Safety (905-335-3663 X3221 or X3347) *IMMEDIATELY* to report a CRITICAL INJURY.

The Employee will report the incident to their Supervisor and together they will complete this form. The Supervisor/Administrator must investigate the incident and indicate corrective actions/preventative measures. The report must be submitted within 48 business hours of the incident in order to avoid WSIB fines.
Scan/email EIR to eir@hdsb.ca or fax to 905-319-0440

Section 1 — EMPLOYEE IDENTIFICATION INFORMATION

Union:	School/Facility/Department Name: ***where incident occurred***	School Phone Number:	Employee ID Number:
Last Name:	First Name:	Sex: ○ Male ○ Female	Date of Birth: *(dd/mm/yyyy)*
Employee Address:	City/Town:	Postal Code:	Home Phone Number:
Employee Job Title:	Assigned School/Facility/Dept. Name: ***if different from where the incident occurred***	○ Permanent Full Time ○ Permanent Part Time ○ Occasional/Casual ○ LTO	

DETAILS OF INCIDENT: Check all that apply

Section 2

Date of Incident: *(dd/mm/yyyy)*	Time of Incident: *(hh:mm)* ○ AM ○ PM	Date Reported: *(dd/mm/yyyy)*	Time Reported: *(hh:mm)* ○ AM ○ PM

Classification of Incident: Check one that applies: **NOTE: If a First Aid or Hazard incident involves aggression/violence, complete an EIR-A form instead of the EIR form.**

- ☐ **First Aid -** *A minor injury was sustained that required attention by a Certified First Aider **or** was self-administered/monitored for further injury.* Complete First Aid information in Section 3
- ☐ **Hazard Only -** *A hazardous situation, near miss or bodily contact that may or may not cause injury*
- ☐ **Health Care -** *Employee sought medical attention which includes an MD, Chiropractor, Physiotherapist, Dentist, Hospital Emergency, etc.* Complete Health Care information in Section 3
- ☐ **Lost Time -** *Time lost following the day of injury (time lost on the day of injury is not included)* Complete Lost Time & Health Care information in Section 3

Name & Position of Witness(es) or persons having knowledge:	Check if Witness:	Work Phone & Extension Numbers:
	☐	
	☐	
	☐	

Name of Person that the Incident was First Reported to:

Location of Incident(s): Check all that apply

☐ Outdoor walkways ☐ Parking Lot ☐ Playground ☐ Indoor foyer/entrance/exit
☐ Blacktop ☐ Office ☐ Stairwell ☐ Hallway
☐ Custodial Office ☐ Cafeteria ☐ Washroom ☐ Classroom
☐ Library ☐ Auditorium
☐ Gymnasium ☐ Off-Site ☐ School Bus/Vehicle
☐ Other (specify): _____

Type of Injury:

☐ Cut ☐ Scratch ☐ Bruise ☐ Strain/Sprain ☐ Pinch ☐ Burn ☐ Puncture wound ☐ Allergic reaction ☐ Other (specify): _____

Body Part Injured: Check all that apply

☐ Head ☐ Face ☐ Eye ☐ Ear ☐ Teeth ☐ Neck ☐ Chest
☐ Upper Back ☐ Mid Back ☐ Lower Back ☐ Abdomen ☐ Other (specify): _____

Left		Right
☐	Shoulder	☐
☐	Arm	☐
☐	Elbow	☐
☐	Forearm	☐

Left		Right
☐	Wrist	☐
☐	Hand	☐
☐	Finger(s)	☐
which digit(s): _____		

Left		Right
☐	Hip	☐
☐	Thigh	☐
☐	Knee	☐
☐	Lower Leg	☐

Left		Right
☐	Ankle	☐
☐	Foot	☐
☐	Toe(s)	☐
which digit(s): _____		

Provide details of injury sustained by employee:

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Last Name:	First Name:	Employee ID #:

Section 2 (continued)

Description of Incident:

1) What happened? *(ie: Employee slipped and fell on right arm)*

2) What was employee doing? *(ie: Employee was walking to her car in the parking lot)*

If more information needs to be documented, use a separate sheet of paper.

Classification Legend: Check one that applies

Section 3

FIRST AID

*A minor injury was sustained that required attention by a Certified First Aider **or** was self-administered/monitored for further injury.*

Was First Aid provided? ◯ No ◯ Yes (If Yes, what First Aid was provided:)

☐ On-Site ☐ Off-Site ☐ Self-Administered ☐ Certified First Aider: First-Aider's Name: _____

HEALTH CARE

Employee sought medical attention which includes an MD. Chiropractor, Physiotherapist, Dentist, Hospital Emergency, etc.

Did the employee receive health care for this injury/illness? ◯ Yes (If yes, provide details below) ◯ No

Date of Health Care treatment: *(dd/mm/yyyy)*	Location of Health Care treatment: *(check all that apply)* ☐ On-Site Health Care ☐ Clinic ☐ Emergency Department ☐ Ambulance ☐ Admitted to Hospital ☐ Health Professional Office (Doctor/Dentist/Chiropractor/Physiotherapist)

Date employer/supervisor learned worker received medical treatment: *(dd/mm/yyyy)*	Name of Health Care Professional:	Address:	Phone Number:

To your knowledge, did the employee speak with their Health Care Professional about returning to modified/regular work? ◯ Yes ◯ No

Are you aware of any prior, similar or related problem, injury or condition? ◯ Yes (If yes, provide details below) ◯ No

◯ **Employee returned to their regular job** / ◯ **Employee returned to modified job**

LOST TIME

Time lost following the day of injury (time lost on the day of injury is not included)

Date Employee last worked: *(dd/mm/yyyy)*	First Day Employee was absent from work: *(dd/mm/yyyy)* ***(not including the day of the incident)***	Date Employee returned to work: *(dd/mm/yyyy)*	Regular Working Hours: Start Time: ◯ AM ◯ PM	End Time: ◯ AM ◯ PM

◯ **Employee returned to their regular job** / ◯ **Employee returned to modified job**

Additional Information (optional):

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Last Name:	First Name:	Employee ID #:

Section 4 (Supervisor's Investigation)

An Incident investigation has four purposes:

1. **To determine why the incident happened by identifying all work related factors associated with it.**
2. **To subsequently modify work conditions and/or procedures to prevent similar occurrences.**
3. **To provide the Ministry of Labour and the Joint Health and Safety Committee with accurate details of the incident as required by the Occupational Health and Safety Act – Regulation 851.**
4. **To provide the Workplace Safety and Insurance Board with accurate details of the incident as required by the WSIB Act and Regulation 1101 – First Aid Requirements.**

All Supervisory Officers, Principals, Managers and other supervisory personnel responsible for work must be totally committed to the incident investigation program.

CAUSE OF INCIDENT (immediate or underlying):

Date of meeting with Employee: *(dd/mm/yyyy)*

What caused the incident?:

Corrective Actions or Preventative Measures Initiated: **check all that apply**

- ☐ Re-instruction for person(s) involved
- ☐ Re-assignment of person(s) involved
- ☐ Safety rules/guidelines provided /reviewed
- ☐ Improper ergonomic conditions resolved
- ☐ Housekeeping or cleaning congested area
- ☐ Installation of guard or safety device
- ☐ Improved design or procedure
- ☐ Discipline of person(s) involved
- ☐ Repair or replacement ordered
- ☐ Use of safer product(s)
- ☐ Acquired/improved PPE (Personal Protective Equipment)
- ☐ Advice given about Safe Footwear/Apparel
- ☐ Incident still under investigation
- ☐ Informed other employees of hazard(s)
- ☐ MSDS (Material Safety Data Sheet) consulted/updated
- ☐ Other (specify):

Further details/comments:

Name of Supervisor completing report:	Supervisor's Title:
Supervisor's Signature:	Date: *(dd/mm/yyyy)*
Employee's Signature: *(denotes receipt of copy – do not delay submission if employee is not able to sign)*	Date: *(dd/mm/yyyy)*

Information on this form is collected under the Occupational Health & Safety Act and the Workplace Safety and Insurance Act in accordance with the Municipal Freedom of Information and Protection of Privacy Act. Information will be used for student and worker safety.