Renfrew County Joint Transportation Consortium

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FIRST AID/INJURY REPORT

A. TO BE COMPLETED BY THE WORKER

INSTRUCTIONS TO INJURED WORKER:

- Please refer to the Health and Safety Procedure for direction on how to report workplace injuries.
- Completely fill out Section A of this report. Sign, date and forward to the RCJTC General Manager for completion.
- Section B is to be completed by the RCJTC General Manager.
- **If seeing a medical professional**, you are required to take with you the ***Treatment Memorandum/Letter to Health Care Practitioner*** **and the** ***Functional Abilities Form (FAF).*** The FAF must be completed during the initial visit by the health professional and returned to the RCJTC General Manager as soon as possible. **You must inform the health professional that MODIFIED WORK IS AVAILABLE FOR ALL INJURIES.**

Section A
WORKER IDENTIFICATION:

Last Name	**First Name**	
911 Address (street #, name, apt., suite, unit)	**City/Town**	**Province**
Postal Code	**Home Telephone**	**Cell Phone**
Date of Birth (dd/mm/yyyy) | |	**Date of Hire (dd/mm/yyyy)** | |	
Employee Type (Job Title)	**Worksite of Injury/Disease (location where occurred)**	

DETAILS OF INJURY:

1. Date and time of injury/disease awareness:	**Date** | |	**Time** ☐ am ☐ pm
Regular scheduled work hours on above date:	**From** ☐ am ☐ pm	**To** ☐ am ☐ pm
2. Date and time injury reported to employer:	**Date** | |	**Time** ☐ am ☐ pm
If not reported immediately, provide reason for delay.		
To whom was the injury reported to?		
3. Type and area of injury – describe injured body part specifying left or right side.		

4. What happened to cause the injury/disease?

5. Describe the worker's activities at the time of the injury/disease. Include details of equipment or materials used and/or the size and weight of objects being handled.

6. Is there anyone who may have witnessed the injury or, is aware of the disease? Please provide details.

Witness Name _____ **Contact Number** _____

Witness Name _____ **Contact Number** _____

7. Was first aid administered on site?

☐ **Yes** ☐ **No**

If so, by whom?

8. Will you be seeking medical treatment for this injury/disease? ☐ **Yes** ☐ **No**
If yes, provide details.

Name of Practitioner/Facility	**Appointment Date**

DECLARATION OF WORKER:

I agree that all the information provided above to be true. I understand that it is my responsibility to update the General Manager of any changes or progressions in this matter.

If, as a result of this injury/disease medical treatment is required or, any work time is lost, I understand that a claim must be made with the Workplace Safety and Insurance Board (WSIB)*. Therefore, if applicable, by signing below I am claiming benefits under the WSIB 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 professional to release information directly to your employer and to the WSIB about your functional abilities.

Signature _____ **Date** _____

Please Note: If you wish to waive your right to claim benefits under the WSIB Act, 1997, for this work-related injury/disease, please advise the General Manager immediately.

B. TO BE COMPLETED BY THE RCJTC GENERAL MANAGER

INSTRUCTIONS TO GENERAL MANAGER:

- Review Section A with the worker and afterwards completely fill out Section B of this report.
- If this is a **critical injury** (i.e. broken bones, excessive blood loss, unconsciousness, etc.), **you must preserve the accident site for investigation**, nothing should be moved or cleaned up.
- **Complete report no later than twenty-four (24) hours after the accident.**
- **Modified work must be discussed with the worker**. **We are able to accommodate all restrictions for a safe and timely return to work.**

Section B
DETAILS OF FOLLOW-UP:

1. Did the employee seek medical aid? ☐ **Yes** ☐ **No**
If so, when did you learn that the worker received medical aid?

2. Was an accident investigation done to determine a cause? ☐ **Yes** ☐ **No**

Investigation Date	**Completed By**

3. What recommendations were made as a result of the investigation?

Recommendations completed? (Give date)	**By (Name/Department)**

4. Have any other steps been taken to prevent a similar accident from happening? ☐ **Yes** ☐ **No**
If yes, please describe.

5. Was any time lost because of this injury/disease? (not including the day of injury) ☐ **Yes** ☐ **No**
If so, list dates and/or time lost.

6. To your knowledge, has the employee had a previous similar injury/disease? ☐ **Yes** ☐ **No**
If yes, please provide details.

7. Modified work is available for all injuries. The General Manager must inform the worker of this.

Was modified work discussed with the worker? ☐ **Yes** ☐ **No**

AUTHORIZATION OF GENERAL MANAGER:

I agree that the details of the injury/disease were reviewed and the information provided herein is correct to the best of my knowledge.

Authorizing Signature _____ **Date** _____