Complete and submit the Employee's Report of Accident/Injury (ERAI) within 48 business hours to the Disability Claim Administration Office:

Fax to 416-393-8533

or

Scan and email to DCMsubmissions@tdsb.on.ca

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.
- This form is meant to report incidents that **involve 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 ERAI, 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

Classification of Incident (First Aid, Health Care, Lost Time)

- Indicate the classification of the incident – read the definition before choosing only **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 Disability Case Administration Office with an email and/or a revised ERAI.

Signatures

- The Principal/VP/Manager/Supervisor must sign and date to acknowledge they have been notified of incident.
- 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 Disability Claim Administration Office.

Reminder: This Employee's Report of Accident/Injury (ERAI) form is only for TDSB staff. For students, parents, or volunteers, refer to the Incident Reporting Centre. http://tdsbweb/_site/ViewItem.asp?siteid=10656&menuid=43324&pageid=36415.

tdsb
Toronto District School Board

Submit to Disability Claim Administration by
Fax: 416-393-8533 or Email: DCMsubmissions@tdsb.on.ca
Please print in black ink

EMPLOYEE'S REPORT OF ACCIDENT/INJURY (ERAI)

Employee Information

Last Name:	**First Name:**		**Employee Number:**	
Address (number, street, spt., suite, unit):			**Phone Number:**	
City/Town:	**Province:**	**Postal Code:**	**Alternate/Cell Phone:**	
Person Completing This Form (if other than injured worker):		**Occupation**	**School/Dept.:**	**Date (dd/mm/yy)**

Employment Information

Job Title: (if you have concurrent assignments, please list all) 1. 2.	**Work Location/School Name:** 1. 2.		
Learning Centre/Area:	**Regular Hours of Work:** **From:** **To:**	**Support:** ☐ Perm ☐ Casual ☐ Acting ☐ Other	**Teaching:** ☐ Perm ☐ Occasional ☐ LTO ☐ Other
Supervisor/Principal's Name & Title:	**Union/Employee Group(s):** (i.e. ETFO/OSSTF, Unit A/B/C/D/E, Schedule II)		

Accident/Illness Dates & Details

	dd mm yy Time
1. **Date and hour of accident/awareness of illness**	| | | | |
2. **Date and hour reported to supervisor**	| | | | |

3. Area of Injury (Body Part) – Please check all that apply

			Left	Right	Left	Right	Left	Right	Left	Right
☐ Head	☐ Teeth	☐ Upper back	☐	☐ Shoulder	☐	☐ Wrist	☐	☐ Hip	☐	☐ Ankle
☐ Face	☐ Neck	☐ Lower back	☐	☐ Arm	☐	☐ Hand	☐	☐ Thigh	☐	☐ Foot
☐ Eye(s)	☐ Chest	☐ Abdomen	☐	☐ Elbow	☐	☐ Finger(s)	☐	☐ Knee	☐	☐ Toe(s)
☐ Ear(s)		☐ Pelvis	☐	☐ Forearm	☐		☐	☐ Lower Leg	☐	

☐ Other: _____

Are you: ☐ **Left Handed** ☐ **Right Handed**

Type of Injury: ☐ Cut ☐ Scratch ☐ Bruise ☐ Strain/Sprain ☐ Pinch ☐ Burn ☐ Puncture wound ☐ Allergic Reaction ☐ Other: _____

4. Did the accident/illness happen on TDSB property or other?	☐ TDSB ☐ Other	**Specify where it happened (classroom, shop floor, parking lot, etc.)**
5. Have you hurt this area(s) of your body before?		
6. Have you had any prior related accidents/injuries? If yes, please provide details (i.e. date, description, etc.		

7. If you had a sudden type of accident/illness, describe your injury and what happened to cause it (e.g. hurt lower back while lifting a 50 pound box, sprained left ankle when I slipped on a wet floor, used a new cleaner and immediately got a rash). Please indicate the size, weights and names of any objects involved.

or

If you had a gradual onset type of injury, describe your injury, the work that you do, and what caused your injury/condition.

(please attach additional sheets if needed)

Accident/Illness Dates & Details (cont.)

8. If you did not report this injury/condition right away, please tell us why.

9. If there were any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, please provide their names & positions.

Name	Position
1.	
2.	

First Aid

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

Did you get first aid or care at work? ☐ Yes ☐ No	**If yes, when:** dd mm yy	**And by whom (name):**

Describe First Aid: *(e.g. applied ice, bandage, etc.)*

☐ Certified First Aider
☐ Co-worker
☐ Self-Administered

Health Care Information

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

1. Did you receive health care for this injury/illness? ☐ Yes (if yes, provide details below) ☐ No

2. Where did you go for health care, for your injury, outside of work? (check all that apply)

		Facility/Hospital (Name, Address & Phone Number)	Date of Visit
☐ On-Site Health Care ☐ Clinic ☐ Emergency Dept.	☐ Ambulance ☐ Admitted to Hospital ☐ Health Professional Office (Doctor/Dentist/Chiro/PT)		| |
		Name of Health Care Professional:	dd | mm | yy

3. Did you talk to your health professional about going back to regular or modified work? ☐ Yes ☐ No **If yes, were you given any work limitations?** ☐ Yes ☐ No

4. Did you tell your supervisor you went for medical treatment? ☐ Yes ☐ No **If no, please report it right away.**

If yes, when? dd mm yy **and to whom?** **Name:** **Position:**

Lost Time

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

1. After the day of accident/illness:

☐ I returned to work my **regular job** and **did not** lose any time or pay.
☐ I returned to **modified duties** and **did not** lose any time or pay.
☐ **I lost time and/or pay** (e.g. regular pay, took a sick or unpaid day)

Date you first lost time and/or pay: dd mm yy

2. If you lost time, have you returned to work? ☐ Yes ☐ No

If yes → **Date of your return to work:** dd mm yy ☐ regular work ☐ modified work

If no → **Did you discuss return to work with your supervisor?** ☐ Yes ☐ No

Employee (Print Name)	**Employee's Signature**	**Date (dd/mm/yy):**
Supervisor/Principal (Print Name)	**Supervisor/Principal's Signature**	**Date (dd/mm/yy):**