Toronto District School Board

Form 659A
Rev. Aug. 2017

EMPLOYEE'S REPORT OF ACCIDENT/INJURY

AFTER FORM IS FULLY COMPLETED, IMMEDIATELY FAX TO DISABILITY CLAIM ADMINSTRATION AT (416) 393-8533.

INJURED WORKER (Report this injury or accident to your Principal/Team Leader/Supervisor immediately.)

PERSONAL INFORMATION	
LAST NAME:	FIRST NAME:
DATE OF BIRTH:	EMPLOYEE NUMBER:
ADDRESS:	CITY: POSTAL CODE:
HOME PHONE:	WORK PHONE:
EMPLOYMENT INFORMATION	
JOB TITLE:	SCHOOL NAME/WORK LOCATION:
REGION/ LEARNING CENTRE:	SUPERVISOR'S NAME:
REGULAR HOURS OF WORK: FROM: TO:	SUPERVISOR'S TITLE:
INJURY INFORMATION	
DATE OF INJURY:	TIME OF INJURY:
DATE & TIME LAST WORKED (**ONLY IF LOSING TIME**):	RETURN DATE (IF KNOWN):
DATE & TIME REPORTED TO PRINCIPAL/TEAM LEADER/SUPERVISOR:	
REGULAR SCHEDULED OVERTIME: DAYS: HOURS: FROM (hrs/min)TO (hrs/min)	

PERSON PROVIDING INFORMATION (IF OTHER THAN INJURED WORKER):		
NAME:	OCCUPATION:	SCHOOL/DEPT:
DATE AND TIME YOU WERE MADE AWARE OF INJURY:		
WITNESS OR PERSON HAVING KNOWLEDGE OF INJURY		
NAME:	OCCUPATION:	SCHOOL/DEPT:

DESCRIPTION OF ACCIDENT (PROVIDE CLEAR, CONCISE, COMPLETE INFORMATION)
1) **DESCRIBE INJURY** (Part of body affected, including left/right side, and type of injury, i.e. pain , cut, bruise, etc.):
2) **ACCIDENT LOCATION**:
3) **HOW DID THE ACCIDENT OCCUR**? (What were you doing? What happened? How did it happen? Problem with equipment? Size/weight/type of materials involved? Building environment? Substandard practices? People?):
4**) HAVE YOU HAD A PREVIOUS SIMILAR INJURY?**

INITIAL TREATMENT OF INJURY – (INDICATE WHICH OF THE FOLLOWING APPLIES) **NOTE** SHOULD ANY OF THE FOLLOWING INFORMATION CHANGE PLEASE REVISE FORM AND FAX IMMEDIATELY**	
( ) FIRST AID only (No medical visit)	
( ) DOCTOR* ( ) HOSPITAL* ( ) CHIROPRACTOR* ( ) PHYSIOTHERAPIST**:**	**DATE OF VISIT:**
*GIVE NAME/ADDRESS/PHONE NO:	

PLEASE ATTACH A SEPARATE PAGE IF MORE SPACE IS REQUIRED.