Centre
de services scolaire
du Littoral
Québec

INCIDENT OR ACCIDENT REPORT

To be completed by the employee

IDENTIFICATION SCHOOL OR CENTER

Name: ____

IDENTIFICATION OF THE INJURED PERSON

Name: ______________________________ First Name: ______________________________

Telephone: _____________________ Employee Number: _________________________________

☐ Teacher ☐ Professional ☐ Support Staff ☐ Management ☐ Other: __________________

DETAILED DECRIPTION OF INCIDENT

Place of incident: _______________________ Date: _______________ Time : ___________

Describe in detail the circumstances surrounding the accident, the task executed at the time, movements or actions, the people involved, the lesion (injury and part of the body injured)

Witness (es): ☐ Yes ☐ No If yes, complete (name, first name, function):

1. ______________________________________ 2. ____

INTERRUPTION OF WORK

☐ Yes ☐ No If yes, what time did the employee finish? ________________________

Beyond the day of the event, did the employee miss work? ☐ Yes ☐ No

If yes, specify: ____

ACTIONS TAKEN FOR THE INJURED PERSON

First-aid: ____

Name of the first-aid person:____

Date and time that the incident was declared to your employer?

____

Other actions? ____

Employee signature: _____________________________ Date: ______________________________

To be completed by the immediate supervisor

ANALYS☺ OF THE EVENTS

What date was it when you were notified of the accident? ________________________

The activity at the time of the accident, was it related to the task? ☐ Yes ☐ No

The physical environment was:

-Well organized	☐ Yes	☐ No
-Accessible	☐ Yes	☐ No
-Well lit	☐ Yes	☐ No
-Clear	☐ Yes	☐ No
-Safe	☐ Yes	☐ No

Factors or causes of the accident or the dangerous incident:

(from the previous elements of analysis, specify the determining and indirect factors or causes of the event. Indicate also, if it is the case, the reasons of the existence of these factors and qualify the relation between the causing agent and the injuries).

Preventative measures recommended:

(Indicate the recommended provisional and permanent corrective measures).

Comments:

Signature of the immediate supervisor: ______________________________ Date: ________________

Forward to the Human Resources Services once completed and signed by the immediate supervisor

What to do in case of a work-related accident?

- The worker must notify the employer or a representative as soon as possible. If unable to do so, a colleague, the union delegate or someone else may do it for you.
- The worker must immediately seek the necessary medical care. The employee will be transported either in a health facility, a doctor of his or her choice or at home if his or her condition is considered serious.
- The CSST must be notified immediately by the employer of all accident that caused serious injuries to the worker or that resulted in his or her death. (L.R.Q., Chapter S-2.1, article 62).
- The employer is required to keep a record of all minor accidents, where a worker had to receive care but did not prevent him or her to continue regular duties beyond the day of the accident. The worker must sign the register.
- The worker will receive for the day of the accident his or her usual salary of all hours he or she would of worked.
- The worker must provide a medical certificate to his or her employer if he or she is incapable to perform his or her job beyond the day of the accident. It is his or her physician who issues the certificate with the diagnosis and the period of healing. The worker must submit a copy of this certificate to his employer in order to be entitled to compensation for work days where he or she is unable to perform his job.
- For the first 14 days off work, it is usually your employer who will pay you 90% of your net salary or wages for the days or parts of days when you would normally have worked. The employer informs the CSST of his or her return to work or the end of the 14 days period (including Saturdays and Sundays) and asks for a reimbursement by completing the *Employer's Notice and Reimbursement Claim* form. The employer gives a copy to his or her employee.
- If the absence exceeds 14 days, the CSST continues to pay the compensation. In order to receive it the worker must complete the *Worker's Claim f*orm, send a copy to the regional office of the CSST closest to home and give a copy to the employer.
- Upon presentation of the *Worker's Claim* form and original receipts, medical expenses and travel costs are reimbursed by the CSST to the employee.
- The employer may assign a temporary employment to a worker that is unable to perform his or her regular duties, provided that the doctor gives the worker a written notice that this work, as described by the employer, is safe, conducive to his rehabilitation and can be done by the worker.
- The worker has the right to return to work or, if it no longer exists, an equivalent position once his or her doctor believes he or she is able to do so. If he or she is incapable to do so, he or she will have the right to occupy the first suitable employment that becomes available.