ONTARIO POSTSECONDARY STUDENT UNPAID WORK PLACEMENT ACCIDENT/ INCIDENT/ILLNESS REPORTING FORM

Human Resources
Health, Safety & Well-being
Your Health.
Your Safety.
Your Well-being.

This form must be completed by the Placement Employer/Training Supervisor and the Student Trainee.

Placement Employer – the organization where the Student Trainee is on placement
Training Supervisor – the name of the supervisor/preceptor responsible for the Student Trainee

This form along with the MCU Postsecondary Student Unpaid Work Placement Workplace Claim Form and Letter of Authorization to Represent Employer must be received by Western Health, Safety & Well-being within 3 business days of the accident/incident/Illness. E-mail completed forms to your nursing-incidents@uwo.ca .

STUDENT INFORMATION

Last Name: First Name:

Home Address (number, street, apt., suite, unit):

City/Town: Province: Postal Code:

Telephone Number: Student number:

ACCIDENT/INCIDENT/ILLNESS (AII) DETAILS

1. Date of accident/incident/illness: Time: a.m. ☐ p.m. ☐

   Date reported to Placement Employer: Time: a.m. ☐ p.m. ☐

2. Name of Training Supervisor the accident/illness was reported to:

   Telephone Number:

3. Description of Accident/Illness/Incident (what happened to cause the AII? What was the person doing? Was there any equipment/people/materials involved?

4. Part of body injured (specify left or right side):

5. Placement site, unit/location/area where the accident/incident took place:

6. Were there any witnesses? Yes ☐ No ☐
   If yes, provide:

   Name of Witness 1:

   Position:

   Telephone Number:

   Name of Witness 2 (if applicable):

   Position:

   Telephone Number:

HEALTH CARE INFORMATION

1. Did the Student Trainee receive first aid for this injury? Yes ☐ No ☐

   If yes, by whom?

2. Did the Student Trainee receive health care of this injury? Yes ☐ No ☐

   If yes, on what date:

   Date when the Placement Employer learned that the Student Trainee received health care:

3. Where was the Student Trainee treated for the injury?
   Name, address and phone number of health professional/facility who treated Student Trainee (if known) and transportation details (e.g., ambulance):

4. Are you aware of any prior similar or related problem, injury or condition? Yes ☐ No ☐
   If yes, explain:

LOST TIME – NO LOST TIME

1. Please choose one of the following indicators. **After the day of the accident/incident/awareness of illness, this Student Trainee:**

☐ Returned to their **regular placement** and **has not** lost any time.

☐ Returned to a **modified work** and **has not** lost any time.

Have you been provided with work limitations for this Student Trainee's injury? Yes ☐ No ☐

Has modified work been discussed with the Student Trainee? Yes ☐ No ☐

Has modified work been offered to the Student Trainee? Yes ☐ No ☐

If yes, did the Student Trainee accept modified work? Yes ☐ No ☐

☐ **Has** lost time. Date Student Trainee first lost time:

Date Student Trainee returned (if known):

Have you been provided with work limitations for this Student Trainee's injury? Yes ☐ No ☐

Has modified work been discussed with the Student Trainee? Yes ☐ No ☐

Has modified work been offered to the Student Trainee? Yes ☐ No ☐

If yes, did the Student Trainee accept modified work? Yes ☐ No ☐

SIGNATURES

Name of Training Supervisor: Telephone Number:

Date: Training Supervisor's Signature:

Name of Student Trainee: Telephone Number:

Date: Student Trainee's Signature: