INVESTIGATIONS and REPORTING

The purpose of the Investigation policy is to investigate incidents so that causes can be determined and corrective actions can be implemented to prevent recurrence.

All accidents/incidents within CPP must be reported to the immediate superintendent/supervisor, which in turn must notify the Health & Safety Advisor.

CPP will fully investigate the following incidents;

- Incidents that result in injuries requiring medical aid.
- Incidents that cause property damage, or interrupt operations with a potential loss exceeding $500.00.
- All incidents that by regulation must be reported to; OH&S and/or other government regulatory agencies.

CPP understands that accidents are the result of unsafe acts or unsafe conditions, or both.
CPP's commitment is to eliminate both unsafe acts and conditions to keep employees and those present at our work sites safe, while our work is conducted. Reporting of all incidents is mandatory in order to determine where our focus for prevention needs to be.

Unsafe conditions are physical hazards such as:

- *Missing Machine Guards*
- *Damaged Equipment*
- *Improper Storage of Materials*
- *Lack of Training*
- *Exposed Electrical Circuits*
- *Slippery Floors*
- *Lack of Supervision*

Unsafe Acts are the things people do that are obviously not safe. Some examples are:

- *Horseplay*
- *Running at the Work Site*
- *Not Properly Lifting*
- *Not Using Specified PPE*
- *Using Damaged Tools*
- *Violating Policies, Procedures, Rules, etc.*

DEFINITIONS USED IN INVESTIGATION REPORTING

Accident - An unplanned event that interrupts the completion of an activity, and that may (or may not) include injury or property damage.

Incident - An unexpected event that did not cause injury or damage this time but had the potential. "Near miss" or "dangerous occurrence" are also terms for an event that could have caused harm but did not.

Please note: *The term incident is used in some situations and jurisdictions to cover both an "accident" and "incident". It is argued that the word "accident" implies that the event was related to fate or chance. When the root cause is determined, it is usually found that many events were predictable and could have been prevented if the right actions were taken -- making the event not one of fate or chance (thus, the word incident is used). For simplicity, we will use the term incident to mean all of the above events.*

First-Aid - When an injury results in a onetime treatment and subsequent observation of minor scratches; cuts; burns; splinters; and so forth, which do not require medical aid, regardless if this care is provided by a physician or registered medical professional, and is able to resume his/her work.
First Aid Incidents are considered not reportable to WCB.

Medical Aid / Treatment - When an employee is injured, then treated by a Physician or registered medical professional (other than first aid), under the standing orders of a physician.
Example: Setting of broken bones; prescribing or administering prescription drugs; suturing wounds; treatment of a second or third degree burn; and so forth. Diagnostic procedure such as x-ray or examinations are not, in themselves, regarded as medical aid treatments. After receiving medical attention, the employee is able to continue with his next scheduled shift.
Medical Aid/Treatment Cases are reportable to WCB.

Restricted Work Case (RWC) - A Restricted Work Case occurs when an employee cannot perform at normal capacity, but does not result in days lost from work. A RWC occurs when, as a consequence of a work related injury or illness. Examples are; the employee is temporarily assigned to another job, the employee cannot perform at normal capacity for all or part of their work shift, and/or the employee works their regularly assigned job but cannot perform all duties normally connected with it.
Restricted Work Cases are reportable to the WCB.

Lost Time / Lost Time Incident (LTI) - When an employee has been injured and has been advised by a Physician to stay off work due to the nature of their injury. The employee is unable to report to their next shift. Lost Time Incidents are reportable to the WCB.

Modified Work - The change in the regular job duties of an employee because of injury or illness. These changes may include tasks or functions, work schedule, workload, work area, and equipment. The modified work program is only for a temporary basis, giving the injured or sick employee a time line to regain normal condition. Modified Work Claims are reportable to the WCB.

RESPONSIBILITIES

All Employees:

It is the responsibility of each employee that is witness to, involved in, or has knowledge of any incident or near miss which led or may have led to damage or injury, to report the events to their Supervisor immediately. Every employee is to be familiar with the requirements of the Incident and Investigation policies, and it is the Manager's and Supervisor's responsibility to see that it is followed.

Superintendents / Supervisors / Foremen:

When an accident/incident occurs on site, it is the responsibility of each site management team to promptly investigate and submit the Incident Report in writing to the Health & Safety Advisor and their Divisional Manager. Incidents resulting in injuries in which the injured worker needs medical aid must be reported via telephone to the Health and Safety Administration immediately.

Health & Safety Administration and Management:

It is the responsibility of the Health and Safety administration and each manager to review, further investigate, or take such action as is deemed necessary to prevent reoccurrence of the events.

REPORTING REQUIREMENTS

Incidents of a nature that require reporting to any government agency, will be done by or under the approval of the Health & Safety Advisor, and/or Superintendent/Supervisor and will be done in accordance with all required legislation such as: Department or Ministry of Environment; OH&S; etc. Examples may include incidents resulting in a worker being admitted to hospital; unplanned or uncontrolled fire; spills in reportable quantities; collapse or upset of a crane; etc.

All employees of CDN. Power Pac are covered by WCB and subject to all of the benefits and requirements of such organizations. It is the responsibility of the Health & Safety Advisor to know the WCB reporting requirements for the jurisdiction for which they are assigned.

An investigator who believes that accidents are caused by unsafe conditions will likely try to uncover conditions as causes. On the other hand, one who believes they are caused by unsafe acts will attempt to find the human errors that are causes. Therefore, it is necessary to examine some underlying factors in a chain of events that ends in an accident. The important point is that even in the most seemingly straightforward accidents, seldom, if ever, is there only a single cause. For example, an "investigation" which concludes that an accident was due to worker carelessness, and goes no further, fails to seek answers to several important questions such as:

- *Was the worker distracted? If yes, why was the worker*
- *Was a Safe Work Procedure being followed? If not, why*
- *Were safety devices in order? If not, why not?*
- *Was the worker trained? If not, why not?*

Reporting Requirements (cont.)

An inquiry that answers these and related questions will probably reveal conditions that are more open to correction than attempts to prevent "carelessness".

INVESTIGATING AN INCIDENT:

The incident investigation process involves the following steps:

- Report the incident occurrence to a designated person within the organization.
- Provide first aid and medical care to injured person and prevent further injuries or damage.
- Investigate the incident.
- Identify the causes.
- Report the findings.
- Develop a plan for corrective action.
- Implement the plan.
- Evaluate the effectiveness of the corrective action.
- Make changes for continuous improvement.

As little time as possible should be lost between the moment of an incident or near miss and the beginning of the investigation. In this way, one is most likely to be able to observe the conditions as they were at the time, prevent disturbance of evidence, and identify witnesses. The tools that members of the investigating team may need (pencil, paper, camera, film, camera flash, tape measure, etc.) should be immediately available so that no time is wasted.
The size and structure of the investigation team should be entirely dictated by the incident's seriousness, training, and/or nature and technical complexity. Each team must have at least one qualified person formally trained in incident investigations. Incidents and near misses that have high loss potential must be thoroughly investigated to determine the root causes and corrective actions.

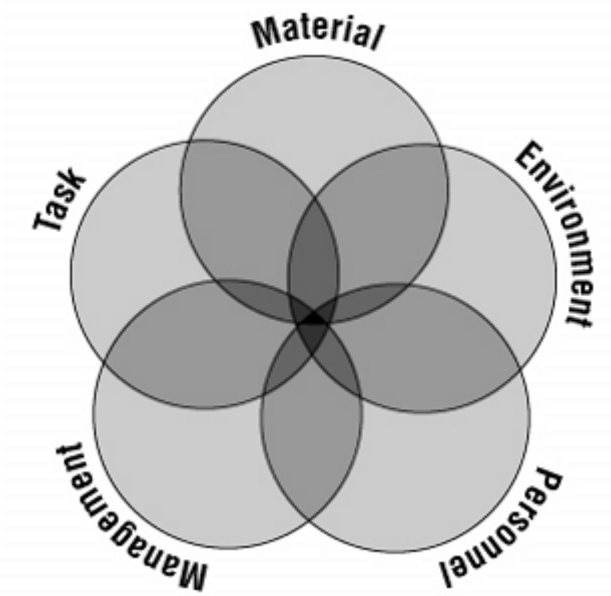
Minor Incident:
The Manager, Health and Safety Advisor with the help of the employees involved, investigate incidents that did or could have resulted in minor injury, minor property damage, or minor environmental impact.

Major/Serious Incident:
The team that needs to be organized to investigate a serious or major incident – one involving a serious injury or potential; or extensive property damage or potential; or a serious environmental incident or potential; should include the employees directly involved, management, Health and Safety Personnel, and selected others not necessarily involved with the incident but are familiar with the job, process, operation or equipment.

INCIDENT CAUSATION MODELS

Many models of incident causation have been proposed, ranging from Heinrich's domino theory to the sophisticated Management Oversight and Risk Tree (MORT).
The simple model shown in *Figure 1* attempts to illustrate that the causes of any incident can be grouped into five categories - *task, material, environment, personnel,* and *management.* When this model is used, possible causes in each category should be investigated. Each category is examined more closely below. Remember that these are sample questions only: no attempt has been made to develop a comprehensive checklist.

Figure 1;



Task:

Here the actual work procedure being used at the time of the accident is explored. Members of the accident investigation team will look for answers to questions such as:

- *Was a safe work procedure used?*
- *Had conditions changed to make the normal procedure unsafe?*
- *Were the appropriate tools and materials available?*
- *Were they used?*
- *Were safety devices working properly?*
- *Was lockout used when necessary?*

For most of these questions, an important follow-up question is “If not, why not?”

Material:

To seek out possible causes resulting from the equipment and materials used, investigators might ask:

- *Was there an equipment failure?*
- *What caused it to fail?*
- *Was the machinery poorly designed?*
- *Were hazardous substances involved?*
- *Were they clearly identified?*
- *Was a less hazardous alternative substance possible and available?*
- *Was PPE used?*
- *Were users of the PPE properly trained?*

Incident Causation Models (cont.)

Environment:

The physical environment, and especially sudden changes to that environment, are factors that need to be identified. The situation at the time of the accident is what is important, not what the "usual" conditions were. For example, accident investigators may want to know:

- *What were the weather conditions?*
- *Was it too hot or too cold?*
- *Was there adequate light?*
- *Was poor housekeeping a problem?*
- *Was noise a problem?*
- *Were toxic or hazardous gases, dust, or fumes present?*

Personnel:

The physical and mental condition of those individuals directly involved in the event must be explored. The purpose for investigating the accident is not to establish blame against someone but the inquiry will not be complete unless personal characteristics are considered. Some factors will remain essentially constant while others may vary from day to day:

- *Were workers experienced in the work being done?*
- *Can they physically do the work?*
- *Were they tired?*
- *Had they been adequately trained?*
- *What was the status of their health?*
- *Were they under stress (work or personal)?*

Management:

Management holds the legal responsibility for the safety of the workplace and therefore the role of supervisors and higher management and the role or presence of management systems must always be considered in an accident investigation. Failures of management systems are often found to be direct or indirect factors in accidents. Ask questions such as:

- *Were safety rules communicated and understood?*
- *Were rules, procedures, and policies being enforced?*
- *Had hazards been previously identified?*
- *Were written procedures and orientation available?*
- *Was there adequate supervision?*
- *Were unsafe conditions corrected?*

This model of accident investigations provides a guide for uncovering all possible causes and reduces the likelihood of looking at facts in isolation. Some investigators may prefer to place some of the sample questions in different categories; however, the categories are not important, as long as each pertinent question is asked. Obviously there is considerable overlap between categories; this reflects the situation in real life.

INVESTIGATION FACT AND INFORMATION COLLECTION

The steps in incident investigation are simple: the incident investigators gather information, analyze it, draw conclusions, and make recommendations. Although the procedures are straightforward, each step can have its pitfalls. As mentioned before, an open mind is necessary in incident investigation: preconceived notions may result in some wrong paths being followed while leaving some significant facts uncovered. All possible causes should be considered. Making notes of ideas as they occur is a good practice but conclusions should not be drawn until all the information is gathered.

Injured workers(s):
The most important immediate tasks--rescue operations, medical treatment of the injured, and prevention of further injuries--have priority and others must not interfere with these activities. When these matters are under control, the investigators can start their work.

Physical Evidence:
Before attempting to gather information, examine the site for a quick overview, take steps to preserve evidence, and identify all witnesses. In *some* jurisdictions, an incident site must not be disturbed without prior approval from appropriate government officials such as the coroner, inspector, or police. Physical evidence is probably the most non-controversial information available. It is also subject to rapid change or obliteration; therefore, it should be the first to be recorded. Based on your knowledge of the work process, you may want to check items such as time of day, equipment being used, weather conditions, housekeeping of area, etc.
You may want to take photographs before anything is moved, both of the general area and specific items. Later careful study of these may reveal conditions or observations missed previously. Sketches of the incident scene based on measurements taken may also help in subsequent analysis and will clarify any written reports. Broken equipment, debris, and samples of materials involved may be removed for further analysis by appropriate experts. Even if photographs are taken, written notes about the location of these items at the accident scene should be prepared.

Eyewitness Accounts:
Although there may be occasions when you are unable to do so, every effort should be made to interview witnesses. In some situations witnesses may be your primary source of information because you may be called upon to investigate an accident without being able to examine the scene immediately after the event. Because witnesses may be under severe emotional stress or afraid to be completely open for fear of recrimination, interviewing witnesses is probably the hardest task facing an investigator.

Investigation Fact and Information Collection (cont.)

Witnesses should be kept apart and interviewed as soon as possible after the accident. If witnesses have an opportunity to discuss the event among themselves, individual perceptions may be lost in the normal process of accepting a consensus view where doubt exists about the facts.
Witnesses should be interviewed alone, rather than in a group. You may decide to interview a witness at the scene of the accident where it is easier to establish the positions of each person involved and to obtain a description of the events. On the other hand, it may be preferable to carry out interviews in a quiet office where there will be fewer distractions. The decision may depend in part on the nature of the accident and the mental state of the witnesses.

Interviewing:

Interviewing is an art that cannot be given justice in a brief document such as this, but a few do's and don'ts can be mentioned. The purpose of the interview is to establish an understanding with the witness and to obtain his or her own words describing the event:

INTERVIEW DO'S	***INTERVIEW DO NOT'S***
• Put the witness at ease	• Intimidate the witness
• Let the witness talk, and listen	• Interrupt the witness
• Confirm that you have the correct statement	• Prompt the witness for statements
• Try to sense underlying feelings of the witness	• Ask leading questions
• Make short notes during the interview	• Show your emotions
• Ask if it's O.K. to record the interview	• Jump to conclusions

Ask open-ended questions that cannot be answered by simply "yes" or "no". The actual questions you ask the witness will naturally vary with each accident, but there are some general questions that should be asked each time. If you were not at the scene at the time, asking questions is a straightforward approach to establishing what happened. Obviously, care must be taken to assess the credibility of any statements made in the interviews. Answers to a first few questions will generally show how well the witness could actually observe what happened. Another technique sometimes used to determine the sequence of events is to re-enact or replay them as they happened. Obviously, great care must be taken so that further injury or damage does not occur. A witness (usually the injured worker) is asked to re-enact in slow motion the actions that preceded the incident.

ANALYSIS AND CONCLUSIONS

At this stage of the investigation most of the facts about what happened and how it happened should be known. This has taken considerable effort to accomplish but it represents only the first half of the objective. Now comes the key question--why did it happen? To prevent recurrences of similar accidents, the investigators must find all possible answers to this question. You have kept an open mind to all possibilities and looked for all pertinent facts. There may still be gaps in your understanding of the sequence of events that resulted in the accident. You may need to re-interview some witnesses to fill these gaps in your knowledge.

When your analysis is complete, write down a step-by-step account of what happened *(your conclusions)* working back from the moment of the accident, listing all possible causes at each step. This is not extra work: it is a draft for part of the final report. Each conclusion should be checked to see if:

- it is supported by evidence.
- the evidence is direct (physical or documentary) or based on eyewitness accounts.
- the evidence is based on assumption.

This list serves as a final check on discrepancies that should be explained or eliminated.

The most important final step is to come up with a set of well-considered recommendations designed to prevent recurrences of similar accidents. Once you are knowledgeable about the work processes involved and the overall situation in your organization, it should not be too difficult to come up with realistic recommendations.
Resist the temptation to make only general recommendations to save time and effort.
In the unlikely event that you have not been able to determine the causes of an accident with any certainty, you probably still have uncovered safety weaknesses in the operation. It is appropriate that recommendations be made to correct these deficiencies.

CORRECTIVE ACTIONS

Managers are responsible for ensuring that recommended Corrective Actions are followed through with. CDN. Power Pac recognizes that failure to follow-up and ensure all corrective action is carried forward to implementation may result in serious implications on other health, safety and environment initiatives. Each Division must ensure that the Incident Report is provided with the correct information so that follow up actions are established, critical items that were identified are corrected, and workers are assigned responsibility to certain actions for completion.

CPP INCIDENT REPORT FORM

Incident Type				□ Actual	□ Near Miss
□ Injury/Illness	□ Environmental	□ Property Damage	□ Vehicle	□ Public Contact	

Who, What, Where, When

Supervisor:		Supervisor Phone:	(000) 000-0000
Superintendent:			
Incident Date:		Time of Incident:	
Worker Type:	□ Employee	□ Contractor	□ Customer
Contractor Company:			
EHS Advisor:		Location:	

Description of Incident (Include working condition at time of incident)

Immediate Actions Taken

People Involved

Primary Person Involved: *(ie: injured, driver, etc.)*		Occupation:		Years of Service:	
Supervisor:		Number of consecutive Days worked:		Hours:	
Person Involved:		Occupation:		Years:	
Supervisor:		Number of consecutive Days worked:		Hours:	
Person Involved:		Occupation:		Years:	
Supervisor:		Number of consecutive Days worked:		Hours:	

Injury / Illness Details

Classification:	□ Report Only	□ First Aid	□ Medical Aid	□ Restricted Work	□ Lost Time	□ Fatality
Character:	□ Stuck by	□ Contact With	□ Exposed	□ Slip	□ Trip	
□ Fall	□ Over Exertion	□ Foreign Body	□ Caught on or Between	□ Other _____		

Name of Injured:	
Occupation:	Supervisor:
Specify the nature of the injury:	
Body Part Injured:	
Specify treatment received including prescribed medications (if any) and work capability as recommended by doctor:	

Property Damage Details: (Complete only if reporting Property Damage incident)	
Equipment Owner:	
Equipment Type:	
Source/Cause of Damage:	

Motor Vehicle Accident Details: (Complete only if reporting MVA incident)						
Accident Type:	☐ Single Vehicle	☐ Third Party	☐ Animal	☐ Other -		
Unit Number:		Make-Model-Year				
Source/Cause of Damage:						
Police Notified:	☐ Yes ☐ No	Report Number:				
Charges Laid:	☐ Yes ☐ No	To Whom:				
Third Party Information:	Driver Name:		Phone:			
Insurance Carrier:		Policy Number:				
Vehicle License Plate:		Make-Model-Year				
Injuries:	☐ Yes ☐ No Describe:					

Environmental Details: (Complete only if reporting Environmental incident)				
☐ On Lease	☐ Off Lease	☐ Body of Water Impacted	☐ Fish Bearing Stream Impacted	☐ Cumulative Release
Type	Substance Released	Estimated Volume	Recovered Volume	Source
☐ Air				
☐ Land				
☐ Water				

Agencies/Individuals Contacted: (Complete only if a result of Immediate Actions taken)	
Agency/Individual:	
Name of Contact:	
Date:	
Note/Reference #:	

Action Plan:			
Action Required	Assigned To	Due Date	Complete
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes

Management Review:						
Corrective Action Required:	☐ Yes ☐ No Describe:					
Estimated Incident Cost:		Recoverable: ☐ Yes ☐ No				
Investigation Required:	☐ Yes ☐ No	Style:	☐ SCAT ☐ TaPRooT ☐ Other -			
Health & Safety Manager:		Signature:		Date:		
Division Manager:		Signature:		Date:		
VP Operations:		Signature:		Date:		

*Upon completion of this report, please fax to the Health & Safety Advisor.

INCIDENT INVESTIGATION FORM

This form must be completed by the site superintendent or site supervisor whenever an accident/incident occurs. An authorized designate for CPP will be responsible for completing this form in the absence of the superintendent and/or supervisor. The site superintendent and/or supervisor must ensure a copy of the completed report is forwarded to the Human Resources Manager.

Accident/Incident resulted in (check all that apply):

☐ Injury ☐ Illness ☐ Property Damage ☐ Near Miss

☐ First-Aid ☐ Medical Aid ☐ Lost Time ☐ Reoccurrence

Site Location	Task being performed:	
Location of Incident (Be specific – area involved)	Date of incident am Time_____ pm	Date reported accident/incident

ACCIDENT/INCIDENT INFORMATION

Supervisor:_____ Date of first missed shift:_____ No. of days lost_____

Approximate date of onset, if no specific date of injury:_____

Object/equipment/substance inflicting damage/injury:_____

Nature of injury:_____ Body parts affected:_____

EMPLOYEE INFORMATION

Name (last name first – please print)

_____ Home phone number:_____

Home Address:_____ Age: _____ Sex: M / F

_____

_____

Date of employment:_____ Occupation/Position: _____

Experience (time) in job:_____

Evaluation of loss potential if not corrected: _____

Loss severity potential: Major ☐ Minor ☐

Probability of occurrence: Low ☐ Moderate ☐ High ☐

Describe how the event occurred:

Immediate causes *(What substandard acts/practices and conditions caused or could cause the event? See end of form)* :

Basic causes *(What specific personal or system factors caused or could cause this event? See end of form)* :

Remedial actions *(What action plan has and/or should be done to prevent a recurrence of the incident in question) :*

Supervisor's Name (print): _____ (signed): _____

Investigator's Name (print) : _____ (signed): _____

Date: _____ Time: _____

IMMEDIATE CAUSES – check all as appropriate	
Substandard Acts/Actions	**Substandard Conditions**
☐ Operating equipment without authority	☐ Inadequate guards or barriers
☐ Failure to warn	☐ Inadequate or improper protective equipment
☐ Failure to secure	☐ Defective tools, equipment or materials
☐ Operating at improper speed	☐ Congestion or restricted action
☐ Making safety devices inoperable	☐ Inadequate warning system
☐ Removing safety devices	☐ Fire and explosion hazard
☐ Using defective equipment	☐ Poor housekeeping, disorder
☐ Failure to use PPE	☐ Hazardous environmental conditions, gases, smoke, dusts, fumes
☐ Improper loading	☐ Noise exposure
☐ Improper placement	☐ Radiation exposure
☐ Improper lifting	☐ High or low temperature exposure
☐ Improper position for task	☐ Inadequate or excess illumination
☐ Servicing equipment in operation	☐ Inadequate ventilation
☐ Horseplay	
☐ Under influence of alcohol and/or other substances	

BASIC CAUSES – check all as appropriate	
Personal Factors	**Job Factors**
☐ Inadequate capability	☐ Inadequate leadership/supervision
☐ Lack of knowledge/training	☐ Inadequate engineering
☐ Lack of skill	☐ Inadequate purchasing
☐ Stress	☐ Inadequate maintenance
☐ Improper motivation	☐ Inadequate tools/equipment
	☐ Inadequate work standards
	☐ Wear and Tear
	☐ Abuse and/or misuse

EMPLOYEE DISCIPLINARY ACTION FORM

Offence Warning:

☐ *First Warning* ☐ *Second Warning* ☐ *Third Warning* ☐ *Final*

Employee Name: _____ ***Date:*** _____

Site/Location: _____ ***Supervisor:*** _____

Disciplinary Procedure Used:

☐ *Verbal Warning* ☐ *Reprimand* ☐ *Suspension* ☐ *Dismissal*

Reason for Disciplinary Actions;

_____

_____

_____

_____

_____

_____

_____

_____

Corrective Actions to be implemented;

_____

_____

_____

_____

_____

_____

_____

Statement of Employee Disciplinary Action Acknowledgement

I have read CPP's Progressive Discipline Policy and Procedures, and understand the disciplinary actions that have been taken for my offence(s), and the corrective actions that will be implemented below to ensure that the offence stated on the previous page will not happen again. I understand that if there is a recurrence of my offence(s), or if any new offence(s) arise, that I may be subjected to further disciplinary procedures up to and including dismissal.

Employee Signature: _____ Supervisor Signature: _____

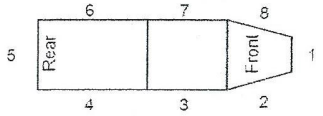
H&S / Management Signature: _____ Date: _____

☐ **Employee**	☐ **Office**	☐ **Superintendent/Supervisor**

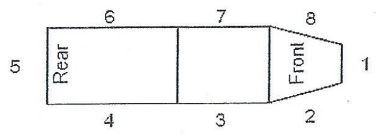
CDN. POWER PAC VEHICLE INCIDENT REPORT

Instructions: In case of an incident involving a company-owned vehicle, the driver of the vehicle must:

1. Report the incident promptly to a local law enforcement agency and obtain a copy of the officer's report.
2. Contact your supervisor and/or fleet manager as soon as practical to report the incident.
3. Within 24 hours of the incident, submit this completed & signed form to your supervisor.

Agency/Dept. Location	Agency/Department Name	Division		Agency Number	
	Supervisor's Name			Phone Number ( )	
	Street Address	City		Postal Code	
Location of the Incident	Street/Highway			Incident Date (mm/dd/yy)	
	City	County	Province	Incident Time	☐ AM ☐ PM
Company Vehicle Information ☐ Assigned ☐ Pool/ Functional	Company Vehicle Owner Agency/Dept. Name	Reason for Vehicle Use			
	Year / Make/Model / Body Type			Mileage	Color
	Fleet Number	Vehicle Identification Number		License Plate Number	
	Describe Parts Damaged		Circle numbered areas of vehicle damage. 		
Information on Driver of Company Vehicle	Driver Name (Print)	☐ Driver Injured ☐ Wearing Seat Belt	Home Phone ( )	Work Phone ( )	
	Email Address	Date of Birth	Driver's License Number		
	Work Address	City	Province	Postal Code	
	Home Address	City	Province	Postal Code	
	Were There Passengers in the Vehicle? ☐ Yes ☐ No If Yes, List Names: _____		Injuries ☐ Yes ☐ No ☐ Yes ☐ No	Wearing Seat Belt ☐ Yes ☐ No ☐ Yes ☐ No	

Information On Vehicle Occupants	Were any of the vehicle passengers sent to a medical facility? ☐ Yes ☐ No Name of Passengers _____ _____ _____ _____ Name of Medical Facility ☐ Yes ☐ No _____ _____ _____ _____

Other Party(s) Involved (add additional sheets if more than one other party involved)			
	(Please indicate what type of property was damaged.) ☐ automobile ☐ fence ☐ building ☐ guard rail ☐ other _____	Describe Parts Damaged	If automobile, circle numbered areas of vehicle damage. 

Property Owner (if different from driver)		Home Phone ( )	Work Phone ( )
Home Address		City	Province / Postal Code
Year / Make/Model		Body Type	License Plate Number
Vehicle Identification Number		Insurance Company	Phone ( )
Agent Name	Address		
Driver Name	☐ Driver Injured ☐ Wearing Seatbelt	Home Phone ( )	Work Phone ( )
Home Address		City	Province / Postal Code
Driver's License Number		Drivers Date of Birth	
Were there passengers in this vehicle? ☐ Yes ☐ No If Yes, List Names: _____		Injuries ☐ Yes ☐ No ☐ Yes ☐ No	Wearing Seat Belt ☐ Yes ☐ No ☐ Yes ☐ No

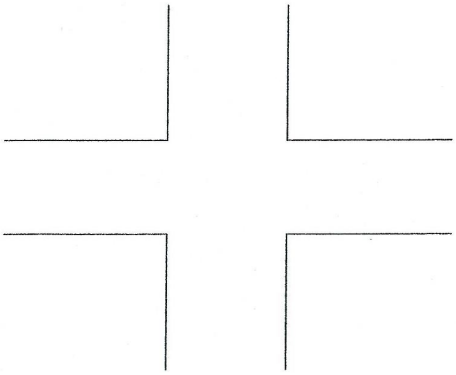
Was the accident investigated by a law enforcement agency? ☐ Yes ☐ No	Were photographs taken at the scene? ☐ Yes ☐ No	By whom?
Name of the Investigating Officer	Law Enforcement Agency Name	Case Number
Were citations issued? ☐ Yes ☐ No	To whom?	
Road Conditions ☐ Wet ☐ Dry ☐ Icy ☐ Other _____	Additional Comments:	Did the other vehicle have lights on? (if other vehicle involved) ☐ Yes ☐ No ☐ Bright ☐ Dim
At what speed were you (Company vehicle) traveling?		Posted Speed Limit

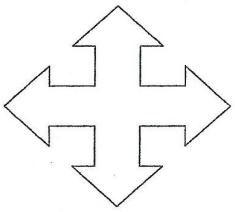
What traffic controls were in effect?	For whom?	Who had the right of way?
What signals were given by you?	What signals were given by the other driver?	
What did you do to avoid the incident?	What did the other driver do to avoid the incident?	

Witness Information	Name of Witness		
	Home Address		Phone Number ( )
	City	Province	Postal Code

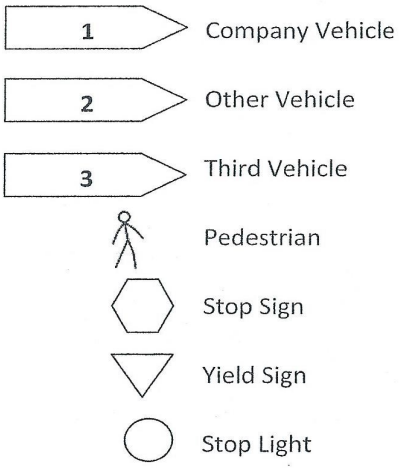
Driver Description of the Incident ☐ Attached sheets include additional description, witness and passenger information.

Please complete this diagram. Indicate names of streets, direction, position of vehicles and point of contact. Use a solid line to show path before the incident and a dotted line to show path after the accident.





Indicate North



As the driver of the company owned vehicle described in this report, I acknowledge that all information provided is true and accurate to the best of my knowledge.	**Scope of Employment Statement** As supervisor of this position, I affirm that the individual named driver was operating the vehicle within his or her authorized scope of employment at the time of the incident. ☐ Yes ☐ No
Name of Driver (Print)	Name of Supervisor (Print)
Signature of Driver (*Required*) Date (mm/dd/yy)	Signature of Supervisor (*Required*) Date (mm/dd/yy)

WCB - EMPLOYER REPORT

Workers' Compensation Board
Alberta

P.O. BOX 2415
EDMONTON AB T5J 2S5

Phone **780-498-3999** (in Edmonton)
1-866-922-9221 (toll free in Alberta)
1-800-661-9608 (outside Alberta)

Fax **780-427-5863** or **1-800-661-1993**

September 2014
EMPLOYER REPORT of Injury C040

Seven Digit Claim # (if available):

Claim Type

1 ☐ Time Lost ☐ Modified Work ☐ Fatality
Complete entire report if claim type is one of the above

☐ No Time Lost (Notice of non-disabling injury/illness)
Complete first page only

Worker Details

Last Name: First Name: Initial:

Mailing Address: Apt# _____ ,

City: Province: Postal Code:

Phone Number:

Social Insurance #:

Personal Health #:

Date of Birth: (Year / Month / Day) Gender: ☐ M ☐ F

Occupation: Job description: Date hired: (Year / Month / Day)

Does the worker have WCB personal coverage with this business? ☐ Yes ☐ No Is the worker a partner or director in this business? ☐ Yes ☐ No

Is the worker an apprentice? ☐ Yes ☐ No If yes, date the worker would have obtained journeyman status: (Year / Month / Day)

Employer Details

Business Name or Government Department:

WCB Account Number: Industry:

2 Employer/Supervisor Contact Name and Title:

Mailing Address:

City:

Province: Postal Code:

Phone: Fax:

Contact Phone:

Contact E-mail:

Accident Details

3 Date/time of accident: (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

Date/time scheduled shift started: (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

Date/time scheduled shift ended: (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

or ☐ the injury/condition developed over time

4 Date accident/injury reported to employer: (Year / Month / Day)

To whom was the accident/injury reported?: Phone Number:

5 Describe fully, based on the information you have, what happened to cause this injury or disease. Please describe what the worker was doing, including details about any tools, equipment, materials, etc., the worker was using. State any gas, chemicals or extreme temperatures worker may have been exposed to:

If you have more information, please attach a letter.

Motor vehicle accident? ☐ Yes ☐ No Cardiac condition/injury? ☐ Yes ☐ No

Letter attached? ☐ Yes ☐ No

Did the accident/injury occur on employer's premises? ☐ Yes ☐ No

6 Location where the accident happened (address, general location or site):

Were the worker's actions at the time of injury for the purpose of your business? ☐ Yes ☐ No

Were the actions part of the worker's regular duties? ☐ Yes ☐ No

Injury Details

What part of body was injured? (hand, eye, back, lungs, etc.) ☐ Left side ☐ Right side

What type of injury is this? (sprain, strain, bruise, etc.)

Employer's Signature: _____ Date: (Year / Month / Day)

C 0 4 0

If you have any other information that would help us make a decision, or if you have concerns, please attach a letter.

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH A DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW OR APPEAL.

C-040 REV SEPT 2014

Page 1 of 2

EMPLOYER REPORT

Worker's Last Name: | Worker's First Name: | Initial:

Social Insurance #: | Date of Birth: (Year / Month / Day)

7 Return to Work Details

a. Will/did you pay the worker regular pay while off work? ☐ Yes ☐ No Has the worker returned to work? ☐ Yes ☐ No

b. Date and time worker first missed work: (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

c. If the worker has returned to work, indicate date: (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

Current work status: ☐ Regular work duties, *or* ☐ Modified work duties ☐ Regular hours of work, *or* ☐ Modified hours of work: _____ hrs per _____

☐ Pre-accident rate of pay, *or* ☐ Revised rate of pay: $ _____ per _____

If the worker is working modified duties, please describe:

d. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? ☐ Yes ☐ No ☐ Was offered but the worker declined

e. Approximate return to work date: (Year / Month / Day) Does the worker have more than one position at your company? ☐ Yes ☐ No

8 Employment Type Details (Complete A or B or C. Select the worker's type of employment.)

A ☐ Permanent position employed 12 months of the year: ☐ Full Time ☐ Part Time ☐ Irregular/Casual

or **B** ☐ Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs): ☐ Seasonal worker ☐ Summer Student ☐ Temporary

Position start date: (Year / Month / Day) Position end date: (Year / Month / Day) ☐ Estimated ☐ Actual

How many months or days per year do you employ workers in this position?

or **C** Alternate employment: ☐ Sub contractor ☐ Piece work ☐ Vehicle owner/operator ☐ Welder owner/operator

☐ Self-employed ☐ Volunteer ☐ Commission ☐ Other

Does the worker incur expenses to perform the work (substantial materials, heavy equipment, larger tools, etc.)? ☐ Yes ☐ No

Will the worker receive a T4? ☐ Yes ☐ No

9 Earnings Details

Earnings information contact name (please print):

Earnings contact phone number: Earnings contact e-mail:

Choose A or B:

A Gross earnings for the period of one year prior to the date of injury or date the worker was hired if less than one year: $ _____ from: (Year / Month / Day) to (Year / Month / Day)

Was any time missed from work **without pay** during the above period, excluding vacation? (eg. maternity, sick, WCB benefits) ☐ Yes ☐ No

Dates and reasons:

or **B** Worker's hourly rate of pay at time of accident: $ _____

Additional taxable benefits:

Vacation Pay ☐ Taken as time off with pay OR ☐ Paid on a regular basis % _____

Shift Premium Gross earnings: $ _____ from: (Year / Month / Day) to (Year / Month / Day)

Overtime Gross earnings: $ _____ from: (Year / Month / Day) to (Year / Month / Day)

Other Gross earnings: $ _____ from: (Year / Month / Day) to (Year / Month / Day)

10 Hours of Work Details

a. Number of hours (not including overtime): _____ per ☐ Day ☐ Week ☐ Shift cycle ☐ Other: _____

b. Does the work schedule repeat? ☐ No ☐ Yes →

Average regular hours worked per week (not including overtime): _____

Date shift cycle commenced: (Year / Month / Day)

Mark hours worked for one complete work schedule (use zero for days off):

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day:							
Hours per day:							
Hours per day:							

IMPORTANT Circle day of injury. See instructions

or *if your schedule is more than 21 days, attach a copy of the schedule.*

C-040 REV SEPT 2014

C 0 4 0

WCB - WORKER REPORT

Workers' Compensation Board
Alberta

PO BOX 2415
EDMONTON AB
T5J 2S5
Phone: **780-498-3999** (in Edmonton)
1-866-922-9221 (toll free in Alberta)
Fax: **780-427-5863** or **1-800-661-1993**

March 2008

WORKER'S REPORT
of Injury or Occupational Disease C060

Seven Digit Claim #:

Worker Information

Past the day of injury: Have you been off work? ☐ Yes ☐ No Have your work duties been modified? ☐ Yes ☐ No

Last Name: | Former Name: (e.g., Maiden Name) | First Name: | Initial:

Address: | Apt #: | Social Insurance #:

City: | Province: | Postal Code: | Health Care #: | Province:

Daytime Phone: | Evening Phone: | Date of Birth: (Year / Month / Day) | Sex: ☐ M ☐ F

Occupation and Job Title at time of injury: | Self employed? ☐ Yes ☐ No → If yes, WCB account #:

E-mail address: | Apprentice? ☐ Yes ☐ No

Employer Information

Business Name or Government Department:

Mailing Address: | Fax:

City: | Province: | Postal Code: | Phone:

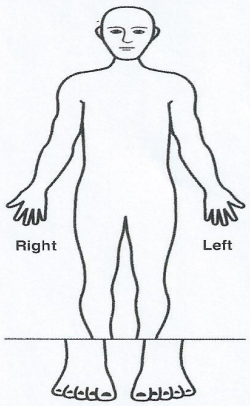
Injury or Occupational Disease Information

1. Date and time of injury: (Year / Month / Day) Time: ☐ a.m. ☐ p.m. **or** ☐ This condition developed over a period of time.
   Scheduled hours of employment on the day of accident: From: To:
2. When was someone at your place of employment notified of your injury? (Year / Month / Day) Time: ☐ a.m. ☐ p.m.
   Name of person and their position: Phone:
   If not reported immediately, give the reason:
3. Did the injury occur on your employer's premises? ☐ Yes ☐ No Did the injury occur in Alberta? ☐ Yes ☐ No
   Location where the accident happened (address or general location):
4. Was the work you were doing for the purpose of your employer's business? ☐ Yes ☐ No If yes, was it part of your usual work? ☐ Yes ☐ No
   Please check the box that best describes the physical demands of your work: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy
   (see detailed description on page 20 of the Worker Handbook)
5. What part of your body was injured? (hand, eye, back, lungs, etc.) ☐ Left side ☐ Right side
6. What type of injury is this? (sprain, strain, bruise, etc.)
7. Describe fully what happened to cause this injury or disease. Describe what you were doing and include any tools, equipment, materials, etc. you were using. State any gas, chemicals or extreme temperatures you have been exposed to:

If you have more information or a list of witnesses, please attach a letter. Please check this box if letter attached. ☐

8. Have you had a similar injury before? ☐ Yes ☐ No **If yes, attach a letter with details.**
9. Have you reported or claimed this injury to another WCB? ☐ Yes ☐ No If yes, which Province or Territory?
10. Full name of treating hospital or healthcare professional:
    Address:
    Phone: Date of first medical treatment: (Year / Month / Day)

Circle part injured
Please check: ☐ Front ☐ Back



C 0 6 0 REV MAR 2008

Complete all three pages and sign the form before sending.

If your injury is the result of a motor vehicle accident, complete the Motor Vehicle Accident Report (L-054).

WORKER'S REPORT

Your Last Name: First Name: Initial:

Social Insurance #: Date of Birth: (Year / Month / Day) Phone:

Time Lost / Return to Work Information

PLEASE COMPLETE ALL THAT APPLY

11 a. Date and time you first missed work: (Year / Month / Day) Time:_____ ☐ a.m. ☐ p.m.

b. Will/did your employer pay you while off work? ☐ No ☐ Yes, pre-accident wages ☐ Yes, but revised rate: $_____ per _____

c. Is there any other work you can do until you are medically fit to return to your regular job? ☐ Yes ☐ No

If yes, who can we call to discuss alternate work on your behalf? Phone:

d. If you have not returned to work give the expected return to work date: (Year / Month / Day)

e. If you have returned to work, indicate the date: (Year / Month / Day) Time_____ ☐ a.m. ☐ p.m. ☐ Regular work, or ☐ Modified work

f. If back on modified work, are you: Being paid your pre-accident rate of pay? ☐ Yes ☐ No – provide rate: $_____ per _____

Working pre-accident hours? ☐ Yes ☐ No – provide hours: _____ per _____

Type of Employment

(Complete A or B or C)

12 A Permanent position employed 12 months of the year: ☐ Permanent full-time ☐ Permanent part-time

or **B** Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs):

☐ Seasonal worker ☐ Temporary position ☐ Casual as needed ☐ Summer student ☐ Volunteer

Had this injury not occurred, your last day of employment would have been: (Year / Month / Day) ☐ Estimated or ☐ Actual

Did you have any other earnings, or income from any other employers, during the last 12 months? ☐ Yes - Please attach copies of pay stubs and/or T4 slips

or **C** Special employment circumstance:

☐ Contractor/sub contractor ☐ Vehicle owner/operator ☐ Welder owner/operator ☐ Commission ☐ Piece work ☐ Other/self-employed

Do you incur expenses to perform the work (materials, tools, etc.)? ☐ Yes ☐ No Will you receive a T4? ☐ Yes ☐ No

Note: If you have checked any box in 12C please submit a detailed income and expense statement.

Wage Information

Date you were hired: (Year / Month / Day)

13 a. Your rate of pay at time of accident: $ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other

b. Additional taxable benefits:

Vacation Pay	☐ Included in rate of pay	%:		OR	☐ Taken as time off with pay
Stat Holiday Pay	☐ Included in rate of pay	%:		OR	☐ Taken as time off with pay
Shift Premium #1	☐ Amount: $		→ Paid per:		
Shift Premium #2	☐ Amount: $		→ Paid per:		
Regular Overtime	☐ Rate: $		→ Number of hours:	per ☐ Week ☐ Month ☐ Shift cycle	
Other	☐ Explain:		→ Amount:	per ☐ Week ☐ Month ☐ Shift cycle	

c. Do you have a second job? ☐ Yes ☐ No If yes – Employer's Name: Phone:
(Second employer may be contacted.)

d. Did you miss time from this second job? ☐ Yes ☐ No If yes, please attach earning information and time missed details.

Hours of Work

14 a. Number of hours (not including overtime): _____ per ☐ Day ☐ Week ☐ Shift cycle ☐ Other

b. Does the work schedule repeat? ☐ No ☐ Yes → Mark hours worked for one complete work schedule (use zero for days off)

Average hours worked per week: _____

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day							
Hours per day							
Hours per day							

IMPORTANT
Circle day of injury.
See instructions

or if your schedule is more than 21 days, attach a copy of the schedule.

c. Date shift cycle commenced (Year / Month / Day)

C 0 6 0 REV MAR 2008

Complete all three pages and sign the form before sending.

WORKER'S REPORT

Your Last Name:	First Name:	Initial:
Social Insurance #:	Date of Birth: (Year / Month / Day)	Phone:

Declaration and Consent

I declare that the information in the 'Worker's Report of Injury or Occupational Disease' form will be true and correct.

I understand that:

- While I am receiving any benefits from WCB, it is my obligation to inform WCB immediately if I return to work of any kind, become capable of working or if there is any other change in my employment status. Work includes but is not limited to any activity in which labour or services are provided, whether or not payment of any kind is received.
- Criminal prosecution may result from any attempt on my part to collect benefits by providing false information, failing to provide information regarding my ability to work, or other fraudulent means.
- My employer may request a review or appeal of any decisions made on my claim and may therefore examine my claim file. My claim file may also be examined by anyone with a direct interest, as determined by WCB, or a person or company I have authorized to review my claim file. (To provide authorization, use the 'Worker's Information Release' form in this booklet).
- My social insurance number may be used for reporting to Canada Revenue Agency.
- WCB may collect information that it considers relevant to determine benefit entitlement, including information pre-dating my accident, from any source including physicians, other health care providers, employer(s) and vocational rehabilitation service providers. This information is collected to determine my entitlement to compensation under the ***Workers' Compensation Act***.

WCB may use and disclose the information collected to determine entitlement, to provide services and benefits and, as required or authorized by law. This information may be used and disclosed pursuant to the ***Workers' Compensation Act*** and the ***Freedom of Information and Protection of Privacy Act***.

Date: (Year / Month / Day) _____ Name (please print): _____

Signature: _____

Signing the above consent enables the Workers' Compensation Board to process your claim.

NOTE: The information required in the Worker's Report is collected under sections 33(a) and (c) of the ***Freedom of Information and Protection of Privacy Act*** for the purpose of determining entitlement to compensation and for determining employers' premium rates. Questions may be directed to the Claims Contact Centre as noted on the front of this form and on the back of the Worker Handbook. The information provided to the Workers' Compensation Board is protected by the provisions of the ***Freedom of Information and Protection of Privacy Act***.

This report form is part of a booklet of information intended to help workers with completing the necessary WCB forms and understanding the process. Keep the booklet for your reference.

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