



**COOPERATIVE EDUCATION PROGRAM**

**STUDENT ACCIDENT REPORT**

**INSTRUCTIONS FOR COMPLETING THIS REPORT:**

- ✓ The Cooperative Education Teacher or Principal must complete this form.
- ✓ Once signed, attach a copy of the Work Education Agreement Form.
- ✓ Send this Report and the Work Education Agreement form to the Disability Management Co-ordinator, Human Resources Department, within 48 hours of accident.
- ✓ If possible, fax to: 1-905-641-0071

STUDENT NAME: \_\_\_\_\_ HOME PHONE NUMBER: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
(STREET) (CITY/TOWN) (POSTAL CODE)

CO-OP WORK LOCATION: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL INSURANCE No.: \_\_\_\_\_

WORKING HOURS: FROM \_\_\_\_\_ To \_\_\_\_\_ DAYS WORKED PER WEEK: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ TIME OF INJURY: \_\_\_\_\_

DATE AND TIME REPORTED: \_\_\_\_\_ INJURY REPORTED TO: \_\_\_\_\_

DID STUDENT SEEK MEDICAL ATTENTION?  YES  NO DOCTOR/HOSPITAL NAME: \_\_\_\_\_

WHAT WAS STUDENT DOING WHEN HE/SHE WAS INJURED? \_\_\_\_\_

WHAT HAPPENED TO CAUSE INJURY/DISEASE \_\_\_\_\_

DESCRIBE INJURED PART OF BODY: \_\_\_\_\_ RIGHT/LEFT/UPPER/LOWER? \_\_\_\_\_

NAME OF WITNESS(ES): \_\_\_\_\_

WILL THE STUDENT LOSE TIME FROM CO-OP.?  YES  NO DATE LAST WORKED: \_\_\_\_\_

IS THIS A RECURRENCE OF AN INJURY?  YES  NO

HAS THE STUDENT BEEN INJURED AT WORK BEFORE?  YES  NO

The new Workplace Safety and Insurance Act, 1997 states that an employee must file his/her claim with the Workplace Safety and Insurance Board (W.S.I.B.). By signing below, you have fulfilled your accident reporting obligations. You may be asked for further information from W.S.I.B.

Signature of the Cooperative Education Teacher who is completing the report: \_\_\_\_\_

Signature of the school's Principal: \_\_\_\_\_