School District # 64 — Report of Injury or near miss

This is an SD 64 form for reporting minor injurys and near miss incidents
Please note that this form is not a Worksafe form but an alternative way for recording information
Notify your supervisor of this report immediately, then copy and send to SD64 Joint Health and Safety Committee

Worker last name	First name	Middle initial	
	Social insurance number		Personal health number from BC CareCard

Incident information

6. Date and time of incident (yyyy-mm-dd) a.m. ☐ p.m ☐ **OR**

7. Period of exposure resulting in occupational disease(yyyy-mm-dd)

8. Have you reported the injury/exposure to your employer? Yes ☐ No ☐

9. The injury or disease was first reported to (please check one) employer on (yyyy-mm-dd)
TO: First aid ☐ Supervisor ☐ Office ☐ Other ☐

10. Name of person reported to

11. If no, provide reason for not reporting to your employer

12. Describe how the incident happened

13. Describe the injury in detail (what part of the body was injured)

14. Side of body injured
Left ☐ Right ☐ Both ☐ Not applicable ☐

15. Describe the work incident location (address, city, province) and where incident occurred (e.g. shop floor, lunchroom, parking lot)

This incident involves a student with special needs. Please contact Director SSS. Review of Safety Plan and IEP is required ☐

16. Did your injury(ies) or exposure result from a specific incident? Yes ☐ No ☐

17. Contributing factors-select AT LEAST ONE, and as many as applicable

Lifting	☐________________lb☐ kg ☐		
Overexertion	☐	Struck	☐
Repetitive(activity repeated over and over again)	☐	Crush	☐
Slip or trip	☐	Sharp edge	☐
Twist	☐	Fire or explosion	☐
Fall	☐	Harmful substance in the work environment	☐

18. Were there any witnesses?
Yes ☐ No ☐

19. Did the incident occur in British Columbia?
Yes ☐ No ☐

20. Were your actions at time of injury for your employer's business?
Yes ☐ No ☐

21. Did the incident occur on employer's premises or an authorized worksite?
Yes ☐ No ☐

22. Did the incident occur during your normal shift?
Yes ☐ No ☐

23. Were you performing your regular work duties at the time of the incident?
Yes ☐ No ☐

24. Did you receive first aid?
Yes ☐ No ☐

If yes, please provide first aid attendant name (if known)

25. Did you go to hospital, clinic, or visit a physician or qualified practitioner?
Yes ☐ No ☐

If yes, please provide provider name (if known)

If yes, please provide provider address(if known)

26. Prior to this incident, did you have any recent pain or disability in the area of your injury?
Yes ☐ No ☐

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Information about you

Worker last name	First name	Middle initial	
Date of Birth (yyyy-mm-dd)	Social insurance number		Personal health number from BC CareCard
Address line 1		Address line 2	
City	Province	Contry(if not in Canada)	Postal code
Home phone number (please include area code)		Business phone number (please include area code)	

School District 64 (Gulf Islands)

Type of business Educational 765008	Operation location School District 64 (Gulf Islands)		
Address 112 Rainbow Road			
City Salt Spring Island	Province BC	Postal Code V8K 2K3	
Employer contact last name Finer	First name Glynis	Employer phone number 250 537 5548	Extension 211

Information about your employment

1. What is your occupation?	2. Have you been employed by this firm for less than 12 months Yes ☐ No ☐	3. If yes, start date (yyyy-mm-dd)

4. At the time of injury, were you (please check all that apply)

Permanent ☐	Apprentice ☐	Self-employed ☐	Casual ☐
Temporary ☐	Volunteer ☐	Hired on a contract basis ☐	Other (please specify) ☐
Full Time ☐	Student ☐		
Part Time ☐	New entrant to workforce ☐		

5. Any other pertinent information?