

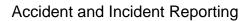
 $Community {\cal F}irst$ 



# All accidents and incidents must be reported within 24 hours to Fax line: 416-932-2670 or emailed to: jenniferb@cfdi.ca

Please attach any applicable documents to the back (ie: police report, pictures, statements)

O Employee	O Tenant/Member	O Visitor				
Date of Accident/Incident:	/Incident:Time of Accident/Incident:					
Name: Address:						
Phone Number:	Alternate Number:					
Location of Accident or Incident:						
Date Supervisor notified:	Time:	AM□PM□				
Please provide details of Acc	dent/Incident or Harassment: (more space is availab	ole on page 3)				
	<u>DETAILS:</u>					
1. Was the accident/illness:	2.Type of accident/illness: (Please check all that apply)					
Sudden Specific Event/Occurrer Gradually Occurring Over Occupational Disease Fatality	Comparison	Slip/Trip Vehicle				
3. Area of Injury (Body Part) – (Plea	<del></del>					
Head Teeth Upper Bar Face Neck Lower Bar Chest Abdome Ear (s) Pelvis Other	ack  Arm  Hand  Finger(s)  Knee	☐ ☐ Toe(s) ☐				
	<b>HEALTH CARE DETAILS:</b>					
2. When did CFDI Management	care for this injury?  Yes  No - If YES, specify da learn that the person received health care? Specify dated for this injury (please check all that apply below):					
On-site First Aid Amb	ulance Health Professional Office Other:					
Name, address and phone nu	mber of health professional or facility who treated th	nis worker (if known)				







#### OTHER PARTY INVOLVED (if applicable):

Name:						
Address:						
Telephone #:	Alternate Number:					
Relationship to injured person:						
Police Report # (Attach if applicable): _						
	WITNESS (If applicable)					
Witness:	Phone #:					
Witness:	s: Phone #:					
PROPER	RTY/DAMAGED EQUIPMENT (If applicable):					
Property/Damaged Equipment:	Est.	Cost:				
Description of Damage:						
EMPLOYEE SECTION ONLY						
LOST TIME/NO LOST TIME (please o	choose one of the following)					
Returned to his/her regular job and has raturned to modified work and has raturned to modified work and has raturned.		┌┐ Regular work				
	Date worker returned:	Modified work				
Management offers a modified work pr	ny, Community First Developments Inc. and Corogram for injured employees. Please speak to ident or injury, regular duties cannot be perform	your HR Representative for				
PLEASE SIGN	N OFF BELOW & CONTINUE TO NEXT TWO PAG	GES				
Signature:	Dat	e:				
Immediate Supervisor:	Dat	e:				
Department Manager:	Dat	e:				

#### Accident and Incident Reporting





Ca	mmunityFirst	below space to record more information, statements etc.





### **Accident Investigation Report**

## This must be completed by the on site manager or senior manager DATE AND TIME INVESTIGATION BEGAN: WAS THERE ANYTHING UNUSUAL ABOUT THE ACTIVITY OF THE INDIVIDUAL THAT COULD HAVE CONTRIBUTED TO THE ACCIDENT? (IE: IMPROPER FOOTWEAR, RUNNING ON WET FLOORS, IMPROPER LIFTING) WERE ESTABLISHED RULES, REGULATIONS AND PROCEDURES BEING FOLLOWED? (IE: PERSONAL PROTECTIVE EQUIPMENT WORN? WHAT COULD BE DONE TO PREVENT A SIMILAR ACCIDENT FROM OCCURRING? WHAT CORRECTIVE ACTION HAS ALREADY BEEN COMPLETED? WHAT CORRECTIVE ACTION IS PLANNED? CORRECTIVE ACTION COMPLETE? ☐ YES ☐ NO COMPLETED BY: DATE: PREPARED BY: DATE: REVIEWED BY: DATE:

FOR OFFICE USE ONLY:				INSURANCE COMPANY: YES	OR	NO	
WSIB: YES	OR	NO					
LOST TIME:	YES	OR	NO	REVIEWED:			
IF ANY LOST TIME, # OF DAYS:							