

As per Ontario Regulation 420/21, a critical injury is an injury of a serious nature that:

- Places life in jeopardy;
- Produces unconsciousness;
- Results in a substantial loss of blood;
- Involves the fracture of a leg or arm, but not a finger or toe;
- Involves amputation of a leg, hand, or foot, but not a finger or a toe;
- Consists of burns to a major portion of the body
- Causes loss of sight in an eye

Supervisor Responsibilities

If a critical injury is confirmed or suspected, the Principal/Supervisor must:

1. Call 911 and / or provide first aid
2. **Immediately secure the scene** (except for purpose of saving life, relieving human suffering, or preventing unnecessary damage to equipment / property)
3. Investigate the incident
4. Report the confirmed or suspected critical injury immediately

If the injury occurs during work hours, report to Health & Safety Officer.

If after hours, report the injury to the Ministry of Labour Reporting Centre at 1-877-202-0008. Follow up with the Health & Safety Officer the following day.

Section A – Personal Information

| | | | |
|---|--|------------------------------|--|
| First Name of Injured Person: | | Last Name of Injured Person: | |
| Home Address: | | City / Town: | |
| Province / Territory: | Country: | Postal Code: | |
| Telephone Number(s): | | Date of Birth (YYYY/MM/DD): | |
| School / Department: | Relationship to employer: <input type="checkbox"/> Employee <input type="checkbox"/> Student <input type="checkbox"/> Visitor | | |
| If injured is a student, list name of Parent(s) / Guardian(s) and relationship to student: (ie. Bob Smith, Parent) | | | |

Section B – Incident Details

| | |
|---------------------------------------|---|
| Date of Incident (YYYY/MM/DD): | Time of Incident (HH:MM am or HH:MM pm): |
|---------------------------------------|---|

Where did the incident occur?
 Be specific, i.e. School name, room number, off-site, department, etc.

Description of incident:

Type of Injury / Area of Body Injured:

| | | |
|--|---|---|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Left elbow | <input type="checkbox"/> Right arm |
| <input type="checkbox"/> Back lower | <input type="checkbox"/> Left eye | <input type="checkbox"/> Right ear |
| <input type="checkbox"/> Back upper | <input type="checkbox"/> Left foot | <input type="checkbox"/> Right elbow |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Left hand | <input type="checkbox"/> Right eye |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Left knee | <input type="checkbox"/> Right foot |
| <input type="checkbox"/> Buttocks | <input type="checkbox"/> Left leg | <input type="checkbox"/> Right hand |
| <input type="checkbox"/> Chest and/or ribs | <input type="checkbox"/> Left lung | <input type="checkbox"/> Right knee |
| <input type="checkbox"/> Chin | <input type="checkbox"/> Left shoulder | <input type="checkbox"/> Right leg |
| <input type="checkbox"/> Circulatory system | <input type="checkbox"/> Left wrist | <input type="checkbox"/> Right lung |
| <input type="checkbox"/> Collar bone | <input type="checkbox"/> Liver | <input type="checkbox"/> Right shoulder |
| <input type="checkbox"/> Digestive system | <input type="checkbox"/> Mouth | <input type="checkbox"/> Right wrist |
| <input type="checkbox"/> Face and facial bones | <input type="checkbox"/> Multiple body parts or systems | <input type="checkbox"/> Sacrum or coccyx |
| <input type="checkbox"/> Finger(s) | <input type="checkbox"/> Neck | <input type="checkbox"/> Skull |
| <input type="checkbox"/> Groin | <input type="checkbox"/> Nervous system | <input type="checkbox"/> Spinal cord / column / vertebra / disc |
| <input type="checkbox"/> Head | <input type="checkbox"/> No physical injury | <input type="checkbox"/> Spleen |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Nose | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Not otherwise classified | <input type="checkbox"/> Thumb |
| <input type="checkbox"/> Kidney(s) | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Toe |
| <input type="checkbox"/> Larynx | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Tooth |
| <input type="checkbox"/> Left ankle | <input type="checkbox"/> Reproductive System | <input type="checkbox"/> Trachea |
| <input type="checkbox"/> Left arm | <input type="checkbox"/> Respiratory System | |
| <input type="checkbox"/> Left ear | <input type="checkbox"/> Right ankle | |

Treatment Details:

Section C. – Investigation

All questions must be answered.

| | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Was the scene held? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Was an investigation conducted? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Had personal protective equipment (PPE) been issued to the employee? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, was the PPE being worn? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Was a job safe practice in place? |

Provide a description of machinery / equipment being used (if applicable):

Provide names of any witness(es)

What are the results of the investigations?

| | | |
|--|--------------------|-------------------------------|
| Indicate recommendations to prevent recurrence: | | |
| Other information / notes to share regarding this critical injury: | | |
| Signature: | Date (YYYY/MM/DD): | Time: (HH:MM; pm or HH:MM am) |

If during work hours, submit this report to to Health & Safety Officer immediately.

If after hours, immediately report the injury to the Ministry of Labour Reporting Centre at 1-877-202-0008

Follow up with the Health & Safety Officer the following day

Rev 01.23