SOUTH SHORE REGIONAL SCHOOL BOARD

Injury on Duty Application Form
Article 26 – Teachers' Provincial Agreement

All teachers are requested to complete this form if injured at work. This report will serve as a record of incident and may serve as background information if an application for "Leave for Injury on Duty" is made in compliance with Article 26 of the Teachers' Provincial Agreement. An SIP "Incident Report Form" is also to be completed.

Please note this form is confidential once completed.

SECTION 1 (to be completed by the Teacher)

Name: ______________________________	Professional Number ______________________________
Usual Work Site ______________________________	Date & Time of Injury ______________________________
Specific Location of Accident ______________________________ ______________________________ ______________________________	Witness(es) to Injury ______________________________ ______________________________ ______________________________
Have you lost time from work? Yes____ No____ If YES: Date of 1st missed day (or part thereof) _______________	Reporting School Board ______________________________

Brief Description of How Injury Occurred (part of body injured, anything that may have contributed to the injury)
____
____
____
____

Describe what you were doing at the time.
____
____

TEACHER: I authorize my health care providers to disclose to my employer all medical information related to my abilities and limitations to perform the duties of my position in respect of this claim.

______________________________ ______________________________
Teacher's Name (signature) Current Assignment
Date ______________________________

PRINCIPAL:

__________ I have reviewed the information provided

__________ I have reviewed the information and wish to provide additional information: (please attach additional written information)

Principal's Name (signature)____________________________ Date ________________________

SECTION 2 (to be completed by the Physician)

What is the nature and extent of your patient's functional impairment?

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____

____

To what extent is this impairment related to the injury that is the subject of this claim?

____

____

____

To what degree is your patient's current functional impairment related to a pre-existing injury, illness or condition?

____

____

____

Dates you attended the patient	Visit #3 __________________________
Visit #1 __________________________	Visit #4 __________________________
Visit #2 __________________________	Visit #5 __________________________

PHYSICIAN: The information provided in this document is true and based on my examination of the patient.

________________________ ______________________ ____________ ________________

Physician's name (print) Mailing Address Work Number Date

____

Physician's signature

SECTION 3 (For HR Use Only)

Approval date __________________________________

Approval signature___________________________

This original, signed form must be submitted to the Director of Human Resources
South Shore Regional School Board (fax ^3012 – 902-541-3012)