SOUTH SHORE REGIONAL CENTRE FOR EDUCATION

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?

_____

_____

_____

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 #1 _____	Visit #3 _____
Visit #2 _____	Visit #4 _____
	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

_____ _____

Physician's signature Date

SECTION 3 (For HR Use Only)

Approval date _____ Approved by (print name)_____

Approval signature_____

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