MIRVISH
PRODUCTIONS

Ed Mirvish Enterprises Limited

Workplace Injury/Incident Report Form

1. Worker Information

Last Name	First Name	Job Title	Employee # (If known)

Address (Number, Street, Apt, Suite, Unit)	Email

City	Province	Postal Code	Phone #	Date of Birth (dd/mm/yyyy)

Is the worker covered by a Union / Collective Agreement?
☐ Yes ☐ No

Sex
☐ Male ☐ Female ☐ Other

2. Accident / Illness Dates and Details

Date and Hour of Incident
dd mm yyyy Time ☐ AM ☐ PM

Date and Hour Reported to Employer
dd mm yyyy Time ☐ AM ☐ PM

Address of Incident
☐ Head Office (322 King St. W, Toronto, ON M5V 1J2)
☐ Royal Alexandra Theatre (260 King St. W, Toronto, ON M5V 1H9)
☐ CAA Theatre (651 Yonge St, Toronto, ON M4Y 1Z9
☐ Princess of Wales Theatre (300 King St. W, Toronto, ON M5V 1J2)
☐ CAA Ed Mirvish Theatre (244 Victoria St. Toronto, ON M5B 1V8)
☐ Other

Exact Location of Incident: (For example: Balcony Lobby, behind the bar)	Name of show being worked on at time of the incident:

Who was the Incident reported to

Last Name	First Name	Job Title	Phone Number

Who was the Incident reported to (If reported to two people)

Last Name	First Name	Job Title	Phone Number

Type of Illness / Accident:
☐ Struck / Caught
☐ Overexertion
☐ Repetition
☐ Fire /
☐ Fall
☐ Harmful Substances / Environmental
☐ Assault
☐ Slip / Trip
☐ Motor Vehicle Incident
☐ Other

Was the Accident / Illness:
☐ Sudden Specific Event / Occurrence
☐ Gradually accruing overtime
☐ Occupational Disease
☐ Fatality

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Brief Description of Incident, Contributing Factors and Additional Information (for example: clothing, weather conditions age/health conditions, etc.)

Area of Injury (Body Part)

☐ Head ☐ Face ☐ Eye(s) ☐ Ear(s) ☐ Teeth ☐ Neck ☐ Chest ☐ Pelvis ☐ Upper Back ☐ Lower Back ☐ Abdomen ☐ Other

	Left	Right
Shoulder	☐	☐
Arm	☐	☐
Elbow	☐	☐
Forearm	☐	☐
Wrist	☐	☐
Hand	☐	☐
Finger(s)	☐	☐
Toe(s)	☐	☐
Hip	☐	☐
Thigh	☐	☐
Knee	☐	☐
Calf	☐	☐
Ankle	☐	☐
Foot	☐	☐

Is there anyone else who may have witnessed or were directly involved with the incident? ☐ Yes ☐ No

If **Yes**:

1. Name	Job Title	Phone Number

2. Name	Job Title	Phone Number

3. Health Care (If known)

Did the worker receive health care for this injury? ☐ Yes ☐ No

If **Yes, when** dd mm yyyy

When did the employeer learn that the worker received health care? dd mm yyyy

Was First Aid Provided? ☐ Yes ☐ No

Who Provided First Aid?

Name	Position	Are they Certified?
		☐ Yes ☐ No

What was done / advice given:

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Was an Ambulance was called?

What time did it arrive: Time ☐ AM ☐ PM

Where was the worker treated for this Injury

☐ On-Site ☐ Ambulance ☐ Emergency Room ☐ Admitted to Hospital ☐ Health Professional Office ☐ Clinic

☐ Other

Facility Information where the worker was treated (If known)

Name	Address	Phone Number

4. Lost Time – Loss of Earnings (If known)

1. Please choose one of the following indicators. After the day of accident/awareness of illness, this worker:

☐ Returned to their regular job and has not lost any time and/or earnings.

☐ Returned to modified work and has not lost any time and/or earnings.

☐ Has lost time and/or earnings. (if so, complete section 5)

Provide date worker first lost time

dd	mm	yyyy

Date worker returned to work (if known)

dd	mm	yyyy

☐ Regular Work

☐ Modified Work

This Lost Time - No Lost Time - Modified Work information was confirmed by:

Name	Job Title	Phone Number

Who is responsible for arranging worker's return to work?

Name	Job Title	Phone Number

5. Wage Information (If known)

Regular Rate of Pay

$ Per ☐ Hour ☐ Day ☐ Week ☐ Other

Normal working hours on last day worked: From: Time ☐ AM ☐ PM To: Time ☐ AM ☐ PM

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6. Work Schedule (If known)

☐ **A. Regular Schedule** - Indicate number of hours worked in a normal week (Example. Sunday: 8 hours, Monday: 4 hours etc.)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

☐ **B. Repeating Rotational Shift Worker** – Provide

Number of days on:	Number of days off:	Hours per shift:	Number of weeks in cycle:

☐ **C. Varied or Irregular Work Schedule -** Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the accident/illness. (Do not include overtime hours or shifts here).

	Week 1	**Week 2**	**Week 3**	**Week 4**
From/To Dates (dd/mm/yy)	/	/	/	/
Total Hours Worked				
Total Shifts Worked				

If needed, Include any Additional Information:

Report Completed By:

Name	Job Title
Email	Date (dd/mm/yyyy)

Last Updated: Nov 17, 2022