Royal Canadian Mounted Police | Gendarmerie royale du Canada

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PIB	RCMP PPE 808

Member's Report of Work Related Illness/Injury

Occupational Health and Safety Branch

This form is intended to document specific work-related physical and/or psychological injuries or illnesses as part of the determination process review to access occupational health benefits.

Member Information

Surname	Given Name	HRMIS No.	Rank	Work Tel. No. (incl. area code)

Address (number, street, apt., suite, unit)	City	Province	Postal Code (A9A 9A9)

Home Tel. No. (incl. area code)	Job Title (at the time you were injured)	How long have you been doing this job for the RCMP?	Years of Service

Employer Information

Royal Canadian Mounted Police

Address

Unit Commander/Supervisor Name	Unit Commander/Supervisor Work Tel. No. (incl. area code)

Accident/Illness Dates and Details

Date of Accident / Awareness of Illness (yyyy-mm-dd)	Time of Accident / Awareness of Illness (hh:mm)	Name of Person You Reported This Accident/Illness to

Position Title of Person You Reported This Accident/Illness to	Tel. No. of Person You Reported This Accident/Illness to (incl. area code)

Area of Injury

☐ Head	☐ Brain	☐ Face	☐ Eyes	☐ Nose	☐ Ears	☐ Teeth
☐ Neck	☐ Chest	☐ Upper Back	☐ Lower Back	☐ Abdomen	☐ Pelvis	☐ Left Shoulder
☐ Right Shoulder	☐ Left Arm	☐ Right Arm	☐ Left Elbow	☐ Right Elbow	☐ Left Forearm	☐ Right Forearm
☐ Left Wrist	☐ Right Wrist	☐ Left Hand	☐ Right Hand	☐ Left Fingers	☐ Right Fingers	☐ Left Hip
☐ Right Hip	☐ Left Thigh	☐ Right Thigh	☐ Left Knee	☐ Right Knee	☐ Left Lower Leg	☐ Right Lower Leg
☐ Left Ankle	☐ Right Ankle	☐ Left Foot	☐ Right Foot	☐ Left Toes	☐ Right Toes	☐ Other

specify:

Which is your dominant hand?	Did the accident/illness happen on the RCMP's property?
○ Left Hand ○ Right Hand	○ Yes ○ No specify where:

If you had a sudden type of accident or illness, describe your injury and what happened to cause it (e.g. I sprained my left ankle when I slipped on a wet floor), or, if you had a gradual onset type of injury (e.g., repeated physical strain or mental stress) describe your injury, the work that you do, and what you believe caused your injury/condition. Please include any additional information at the end of this form.

When did you first start to have problems with this injury/condition?

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Member Surname	Member Given Name	HRMIS No.

Have you injured this area / these areas of your body before? ◯ Yes ◯ No

Did you suffer an injury to this area of your body previously at work? ◯ Yes ◯ No

If you did not report this to your supervisor right away, please tell us the reason why.

If there was a witness to your accident, or if you mentioned your pain or problems to your supervisor or co-worker, please provide names and position information.

Witness 1 Name	Witness 1 Position	Witness 1 Tel. No. (incl. area code)
Witness 2 Name	**Witness 2 Position**	**Witness 2 Tel. No. (incl. area code)**

Health Care Information

Did you seek first aid or care at work? ◯ Yes ◯ No

Name of Person From Who You Sought First Aid / Care at Work	Date of First Aid / Care at Work (yyyy-mm-dd)

Indicate if emergency medical dispatchers / ambulance attended. ◯ Yes ◯ No

Name and Address of Facility/Hospital Where You Sought Health Care for Your Injury, Outside of Work	Date of Facility/Hospital Visit (yyyy-mm-dd)

Where did you seek health care for your injury, outside of work? (check all that apply)

- ☐ Nursing Station
- ☐ Emergency Department
- ☐ Admitted to Hospital
- ☐ Health Professional Office
- ☐ Medical Clinic, Urgent Care Centre
- ☐ Dental Clinic
- ☐ Other specify:

Were you prescribed any medications? ◯ Yes ◯ No

Were you referred for any other treatments or tests? ◯ Yes ◯ No

Did you advise your supervisor that you sought medical treatment? ◯ Yes ◯ No

If you did not advise your supervisor that you sought medical treatment, please tell them right away.

Name of Supervisor Advised That You Sought Medical Treatment	Date Supervisor Advised (yyyy-mm-dd)

Additional Information

Add additional information below

Declarations and Submission

The information is collected by the Royal Canadian Mounted Police Occupational Health Services in order to administer the occupational health programs as per the *RCMP Act* and *RCMP Regulations, 2014*. The information will be collected and maintained pursuant to the *Privacy Act*. The information will be held in accordance to the Personal Information Bank PPE 808.

☐ I declare that all of the Information provided on this form is true to the best of my knowledge.

Submitted by Name	Date Submitted (yyyy-mm-dd)