

# Brock University

## WORK/EDUCATION AGREEMENT FORM

### **Instructions;**

Each participant in an unpaid work/training placement where the work/training placement is a program requirement must have this form completed by a representative of the employer and then return it to his/her work placement coordinator before the placement begins. Participants are eligible for WSIB (or private) insurance coverage provided by the Ministry of Training Colleges and Universities if; the position is unpaid and the individual participates, however minimally, in the activities of the placement host's industry. Participating in the activities of the workplace includes job shadowing/twinning.

At the end of each semester the Brock departmental placement coordinator(s) will compile the information (number of students, type of placement and hours worked/student) on a data summary form and submit the summary to the EHS office (oehs@brocku.ca), so that the totals can be submitted to MTCU who will pay the insurers.

**IN THE EVENT OF ACCIDENT OR INJURY, PLEASE FOLLOW THE INSTRUCTIONS ON REVERSE OF PAGE TWO.**

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## STUDENT INFORMATION/PLACEMENT FORM

Student Name: \_\_\_\_\_ Student #: \_\_\_\_\_ Visa Student? Yes ☐ No ☐

Brock Course/Program: \_\_\_\_\_ Total Number of Work Hours: \_\_\_\_\_

Start Date: \_\_\_\_\_ Finish Date: \_\_\_\_\_

Name of Brock Placement Coordinator: \_\_\_\_\_

Training Participant (Student) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Is the Employer Organization insured by the Workplace Safety and Insurance Board? YES ☐ NO ☐

Does the Employer Organization have a written Health and Safety Policy? YES ☐ NO ☐

Does the Employer Organization have a Health and Safety Committee? YES ☐ NO ☐ NA ☐

Are workplace inspections conducted? YES ☐ NO ☐

### Employer Placement Contact

### Employer Safety Contact

Contact Name:

Job Title:

Phone/Email:

Office Hours:

Contact Name:

Job Title:

Phone/Email:

Office Hours:

**Employer Signature (Placement Contact):**

\_\_\_\_\_ **Date:** \_\_\_\_\_

WHITE COPY: Please send to the Appropriate Brock Program Placement Coordinator

PINK COPY: Retained by Employer

# ACCIDENT or ILLNESS REPORT FORM

(For Brock Students on Work Placements)

## IF AN ACCIDENT OR WORK RELATED ILLNESS OCCURS:

- In the event of a workplace accident while on a work/training placement the host (employer) will fill out the following form and fax a copy to Brock University HR/EHS at 905-688-8481.
- A copy of the work education agreement form will also be faxed (additional information)
- Brock University must submit a Form 7 to the WSIB with 48 hours. Please complete the form and submit within 24 hours.
- Brock University HR/EHS will manage all accident claims. Claims will be paid from the MTCU financed account. Fines for late submissions by an employer are not the responsibility of Brock University. It is the employer's responsibility to notify Brock in a timely manner.
- **In the event of a critical injury**; it is the Employers responsibility to notify the nearest office of the Ministry of Labour. Brock University Staff will participate in any accident or illness investigation involving Brock Students. Contact Brock HR/EHS staff at 905-688-5550 x3274 during normal business hours or x3200 after hours).

**Brock University must notify the Workplace Safety and Insurance Board within 2 days of an injury occurring.**

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Student's Full Name: \_\_\_\_\_ Male ☐ Female ☐

Home Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Student Number: \_\_\_\_\_

SIN#: \_\_\_\_\_ D/M/Y of Birth:        /        /

D/M/Y of Accident:        /        /        Time of Day: \_\_\_\_\_ a.m. ☐ \_\_\_\_\_ p.m. ☐

Ambulance Required? YES ☐ NO ☐        Lost Time? YES ☐ NO ☐

Normal Placement Hours for Week of Injury: S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐

Describe any injury, specifying the exact part of the body involved and any first aid administered.

Names and phone numbers of witnesses/persons having knowledge of accident:

Witness #1: Name: \_\_\_\_\_ Number: \_\_\_\_\_

Witness #2: Name: \_\_\_\_\_ Number: \_\_\_\_\_

Witness #3: Name: \_\_\_\_\_ Number: \_\_\_\_\_

Contact person and phone number for further information:

Name: \_\_\_\_\_ Number: \_\_\_\_\_

Name and phone number of person completing this form:

Name: \_\_\_\_\_ Number: \_\_\_\_\_