Annapolis Valley Regional School Board
Working Together for Students

Injury on Duty Application Form

Teachers' Provincial Agreement

305.15 Appendix E

Sections 1 & 2 must be completed for claim to be considered

SECTION 1 (to be completed by the Teacher)

Name ______________________	Professional Number __________	Phone Number __________
School ______________________	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) __________	Date SIP Form was completed ______________________	

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 ______________________

Home Address____

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 ______________

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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?

____

____

____

Do you believe this injury is likely to result in a permanent impairment?

❑ Yes ❑ No

Additional Information:____

Has your patient been referred to a physiotherapist, chiropractor or specialist?

____

____

____

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)	Work Phone Number	Date

______________________	______________________________________
Physician's Signature	Clinic Mailing Address

Please submit with Section 1 & 2 completed to:

Director of Human Resources
via Board mail, or email, or
HR Confidential Fax: 902-538-4635

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