Accident Report
Statement of Work Placement
Employer and Training Agency

ACE INA Insurance
130 King Street West
12th Floor
Toronto, Ontario
M5X 1A6

SGC 102845

Name of Work Placement Employer _____

Name of Training Participant _____

Date Work Commenced _____ 20___

Is the Training Participant covered by the Workplace Safety Insurance Board Coverage? _____ Yes _____ No

Date last worked _____ 20___

Reason Training Participant ceased work _____

Description of accident: _____

Witness to accident: _____

If Training Participant has returned to work, give date of return _____ 20____

Describe exact duties of Training Participant prior to the date of accident or attach copy of job description _____

If Training Participant has returned to work, have you modified the duties due to the accident? Yes ____ No ____
If "Yes", please describe

Date _____ 20____

_____ By _____
Name of Work Placement Employer's Authorized Representative (Please print) — Signature

_____ By _____
Name of Training Agency's Authorized Representative (Please Print) — Signature