# 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