

Claim Number

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A. Worker Information

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|--|--|---|-------------|---|--|
| Job Title/Occupation (at the time of accident/illness - do not use abbreviations) | | Length of time in this position while working for you | | Social Insurance Number | |
| Please check if this worker is a: <input type="checkbox"/> executive <input type="checkbox"/> elected official <input type="checkbox"/> owner <input type="checkbox"/> spouse or relative of the employer | | | | | |
| Last Name | | First Name | | Worker Reference Number | |
| Address (number, street, apt., suite, unit) | | | | Date of Birth dd mm yy | |
| City/Town | | Province | Postal Code | Telephone | |
| Is the worker covered by a Union/Collective Agreement? <input type="checkbox"/> yes <input type="checkbox"/> no | | | | Worker's preferred language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other | |
| Sex <input type="checkbox"/> M <input type="checkbox"/> F | | | | Date of Hire dd mm yy | |

B. Employer Information

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|---|----------|---|---------------------|
| Trade and Legal Name (if different provide both) | | Check one: <input type="checkbox"/> Firm Number OR <input type="checkbox"/> Account Number | Provide Number |
| Mailing Address | | Class/Subclass | NAICS Code |
| City/Town | Province | Postal Code | Telephone |
| Description of Business Activity | | Does your firm have 20 or more workers? <input type="checkbox"/> yes <input type="checkbox"/> no | FAX Number |
| Branch Address where worker is based (if different from mailing address - no abbreviations) | | | |
| City/Town | Province | Postal Code | Alternate Telephone |

C. Accident/Illness Dates and Details

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| 1. Date and hour of accident/Awareness of illness dd mm yy AM PM Date and hour reported to employer dd mm yy AM PM | | 2. Who was the accident/illness reported to? (Name & Position) Telephone Ext. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Was the accident/illness: <input type="checkbox"/> Sudden Specific Event/Occurrence <input type="checkbox"/> Gradually Occurring Over Time <input type="checkbox"/> Occupational Disease <input type="checkbox"/> Fatality | | 4. Type of accident/illness: (Please check all that apply) <input type="checkbox"/> Struck/Caught <input type="checkbox"/> Overexertion <input type="checkbox"/> Repetition <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Fall <input type="checkbox"/> Harmful Substances/Environmental <input type="checkbox"/> Assault <input type="checkbox"/> Other <input type="checkbox"/> Slip/Trip <input type="checkbox"/> Motor Vehicle Incident | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. Area of Injury (Body Part) - (Please check all that apply) <table border="0"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Teeth</td> <td><input type="checkbox"/> Upper back</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> </tr> <tr> <td><input type="checkbox"/> Face</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Lower back</td> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Ankle</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Eye(s)</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Arm</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Thigh</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Foot</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Ear(s)</td> <td></td> <td><input type="checkbox"/> Pelvis</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Finger(s)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Knee</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Toe(s)</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td></td> <td></td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td><input type="checkbox"/> Lower Leg</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table> | | | | <input type="checkbox"/> Head | <input type="checkbox"/> Teeth | <input type="checkbox"/> Upper back | Left | Right | Left | Right | Left | Right | Left | Right | <input type="checkbox"/> Face | <input type="checkbox"/> Neck | <input type="checkbox"/> Lower back | <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> Wrist | <input type="checkbox"/> | <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> Ankle | <input type="checkbox"/> | <input type="checkbox"/> Eye(s) | <input type="checkbox"/> Chest | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> Thigh | <input type="checkbox"/> | <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> Ear(s) | | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Elbow | <input type="checkbox"/> | <input type="checkbox"/> Finger(s) | <input type="checkbox"/> | <input type="checkbox"/> Knee | <input type="checkbox"/> | <input type="checkbox"/> Toe(s) | <input type="checkbox"/> | <input type="checkbox"/> Other | | | <input type="checkbox"/> Forearm | <input type="checkbox"/> | | | <input type="checkbox"/> Lower Leg | <input type="checkbox"/> | | |
| <input type="checkbox"/> Head | <input type="checkbox"/> Teeth | <input type="checkbox"/> Upper back | Left | Right | Left | Right | Left | Right | Left | Right | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Face | <input type="checkbox"/> Neck | <input type="checkbox"/> Lower back | <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> Wrist | <input type="checkbox"/> | <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> Ankle | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Eye(s) | <input type="checkbox"/> Chest | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> Thigh | <input type="checkbox"/> | <input type="checkbox"/> Foot | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Ear(s) | | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Elbow | <input type="checkbox"/> | <input type="checkbox"/> Finger(s) | <input type="checkbox"/> | <input type="checkbox"/> Knee | <input type="checkbox"/> | <input type="checkbox"/> Toe(s) | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other | | | <input type="checkbox"/> Forearm | <input type="checkbox"/> | | | <input type="checkbox"/> Lower Leg | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc. . .). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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|-------------|-------------------------|
| Worker Name | Social Insurance Number |
|-------------|-------------------------|

C. Accident/Illness Dates and Details (Continued)

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|---|---|
| 7. Did the accident/illness happen on the employer's premises (owned, leased or maintained)? <input type="checkbox"/> yes <input type="checkbox"/> no | Specify where (shop floor, warehouse, client/customer site, parking lot, etc..). |
| 8. Did the accident/illness happen outside the Province of Ontario? <input type="checkbox"/> yes <input type="checkbox"/> no | If yes , where (city, province/state, country). |
| 9. Are you aware of any witnesses or other employees involved in this accident/illness? <input type="checkbox"/> yes <input type="checkbox"/> no | If yes , provide name(s), position(s), and work phone number(s). 1. _____ 2. _____ |
| 10. Was any individual, who does not work for your firm, partially or totally responsible for this accident/illness? <input type="checkbox"/> yes <input type="checkbox"/> no | If yes , please provide name and work phone number _____ |
| 11. Are you aware of any prior similar or related problem, injury or condition? <input type="checkbox"/> yes <input type="checkbox"/> no | If yes , please explain |
| 12. If you have concerns about this claim, attach a written submission to this form. <input type="checkbox"/> submission attached | |

D. Health Care

| | |
|---|---|
| 1. Did the worker receive health care for this injury? <input type="checkbox"/> yes <input type="checkbox"/> no If yes , when : dd mm yy | 2. When did the employer learn that the worker received health care? dd mm yy |
| 3. Where was the worker treated for this injury? (Please check all that apply) <input type="checkbox"/> On-site health care <input type="checkbox"/> Ambulance <input type="checkbox"/> Emergency department <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Health professional office <input type="checkbox"/> Clinic <input type="checkbox"/> Other: _____ Name, address and phone number of health professional or facility who treated this worker (if known). _____ _____ | |

E. Lost Time - No Lost Time

| | | | |
|--|--|---|--|
| 1. Please choose one of the following indicators. After the day of accident/awareness of illness, this worker: <input type="checkbox"/> Returned to his/her regular job and has not lost any time and/or earnings. (Complete sections G and J). <input type="checkbox"/> Returned to modified work and has not lost any time and/or earnings. (Complete sections F, G, and J). <input type="checkbox"/> Has lost time and/or earnings. (Complete ALL remaining sections). | | | |
| Provide date worker first lost time dd mm yy | Date worker returned to work (if known) dd mm yy | <input type="checkbox"/> regular work <input type="checkbox"/> modified work | |
| 2. This Lost Time - No Lost Time - Modified Work information was confirmed by: <input type="checkbox"/> Myself <input type="checkbox"/> Other Name _____ Telephone _____ Ext. _____ | | | |

F. Return To Work

| | | | |
|---|--|--|---|
| 1. Have you been provided with work limitations for this worker's injury? <input type="checkbox"/> yes <input type="checkbox"/> no | 2. Has modified work been discussed with this worker? <input type="checkbox"/> yes <input type="checkbox"/> no | 3. Has modified work been offered to this worker? <input type="checkbox"/> yes <input type="checkbox"/> no | If yes , was it <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <input type="checkbox"/> If Declined please attach a copy of the written offer given to the worker. |
| 4. Who is responsible for arranging worker's return to work <input type="checkbox"/> Myself <input type="checkbox"/> Other Name _____ Telephone _____ Ext. _____ | | | |

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|-------------|-------------------------|
| Worker Name | Social Insurance Number |
|-------------|-------------------------|

G. Base Wage/Employment Information - (Do not include overtime here)

1. Is this worker (Please check all that apply)

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Permanent Full Time | <input type="checkbox"/> Casual/Irregular | <input type="checkbox"/> Student | <input type="checkbox"/> Registered Apprentice | <input type="checkbox"/> Owner Operator or (Sub) Contractor |
| <input type="checkbox"/> Permanent Part Time | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Unpaid/Trainee | <input type="checkbox"/> Optional Insurance | |
| <input type="checkbox"/> Temporary Full Time | <input type="checkbox"/> Contract | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> Temporary Part Time | | | | |

2. Regular rate of pay \$ _____ per ☐ hour ☐ day ☐ week ☐ other _____

H. Additional Wage Information

| | |
|---|--|
| 1. Net Claim Code or Amount Federal <input type="text"/> Provincial <input type="text"/> | 2. Vacation pay - on each cheque? <input type="checkbox"/> yes <input type="checkbox"/> no Provide percentage _____ % |
| 3. Date and hour last worked dd mm yy <input type="checkbox"/> AM <input type="checkbox"/> PM | 4. Normal working hours on last day worked From <input type="checkbox"/> AM <input type="checkbox"/> PM To <input type="checkbox"/> AM <input type="checkbox"/> PM |
| 5. Actual earnings for last day worked \$ _____ | 6. Normal earnings for last day worked \$ _____ |
| 7. Advances on wages: Is the worker being paid while he/she recovers? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, indicate: <input type="checkbox"/> Full/Regular <input type="checkbox"/> Other _____ | |

8. Other Earnings (Not Regular Wages): Provide the **total of additional earnings** for each week for the 4 weeks before the accident/illness.

* For Rotational Shift workers - If the shift cycle exceeds 4 weeks, please attach the earnings information for the last complete shift cycle prior to the date of accident/illness.

Use these spaces for any other earnings (indicate Commission, Differentials, Premiums, Bonus, Tips, In Lieu %, etc..).

| Period | From Date (dd/mm/yy) | To Date (dd/mm/yy) | Mandatory Overtime Pay | Voluntary Overtime Pay | | | | |
|--------|----------------------|--------------------|------------------------|------------------------|----|----|----|----|
| Week 1 | | | \$ | \$ | \$ | \$ | \$ | \$ |
| Week 2 | | | \$ | \$ | \$ | \$ | \$ | \$ |
| Week 3 | | | \$ | \$ | \$ | \$ | \$ | \$ |
| Week 4 | | | \$ | \$ | \$ | \$ | \$ | \$ |

I. Work Schedule (Complete either **A, B or C. Do not** include overtime shifts)

☐ **(A.) Regular Schedule** - Indicate normal work days and hours.

► **Example:** Monday to Friday, 40 hours

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|--------|--------|---------|-----------|----------|--------|----------|
| | | | | | | |

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | | | | | |

or,

☐ **(B.) Repeating Rotational Shift Worker** - Provide

| NUMBER OF DAYS ON | NUMBER OF DAYS OFF | HOURS PER SHIFT(s) | NUMBER OF WEEKS IN CYCLE |
|-------------------|--------------------|--------------------|--------------------------|
| | | | |

or,

☐ **(C.) Varied or Irregular Work Schedule** - Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the accident/illness. (Do not include overtime hours or shifts here).

| | Week 1 | Week 2 | Week 3 | Week 4 |
|--------------------------|--------|--------|--------|--------|
| From/To Dates (dd/mm/yy) | | | | |
| Total Hours Worked | | | | |
| Total Shifts Worked | | | | |

J. It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I declare that all of the information provided on pages 1, 2, and 3 is true.

| | |
|--|------------------------------|
| Name of person completing this report (please print) | Official title |
| Signature | Telephone Ext. Date dd mm yy |

THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER

| Claim Number | Claim Description | Amount | Status |
|--------------|-------------------|--------|--------|
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|-------------|-------------------------|
| Worker Name | Social Insurance Number |
|-------------|-------------------------|

K. Additional Information

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.