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Toronto ON M5V 3J1

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OR 1-888-313-7373

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wsib.ca

7 Employer's Report of Injury/Disease (Form 7)

Claim Number

Please PRINT in black ink

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations)

Start >

Length of time in this position while working for you

Social Insurance Number

Please check **if** this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name | First Name

Address (number, street, apt., suite, unit)

City/Town | Province | Postal Code

Is the worker covered by a Union/Collective Agreement? ☐ yes ☐ no

Worker Reference Number

Worker's preferred language ☐ English ☐ French ☐ Other

Date of Birth dd mm yy

Telephone

Sex ☐ M ☐ F

Date of Hire dd mm yy

B. Employer Information

Fold here for #10 envelope

Trade and Legal Name (if different provide both)

Check one: ☐ Firm Number **OR** ☐ 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? ☐ yes ☐ 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

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:
☐ Sudden Specific Event/Occurrence
☐ Gradually Occurring Over Time
☐ Occupational Disease
☐ Fatality

4. Type of accident/illness: **(Please check all that apply)**
☐ Struck/Caught
☐ Overexertion
☐ Repetition
☐ Fire/Explosion
☐ Fall
☐ Harmful Substances/Environmental
☐ Assault
☐ Other
☐ Slip/Trip
☐ Motor Vehicle Incident

5. Area of Injury (Body Part) - **(Please check all that apply)**
☐ Head ☐ Face ☐ Eye(s) ☐ Ear(s)
☐ Teeth ☐ Neck ☐ Chest
☐ Upper back ☐ Lower back ☐ Abdomen ☐ Pelvis
☐ Other
Left ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm Right ☐
Left ☐ Wrist ☐ Hand ☐ Finger(s) Right ☐
Left ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg Right ☐
Left ☐ Ankle ☐ Foot ☐ Toe(s) Right ☐

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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7 Employer's Report of Injury or Illness (Form 7)

Claim Number

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Worker Name	Social Insurance Number

C. Accident/Illness Dates and Details (Continued)

7. Did the accident/illness happen on the employer's premises (owned, leased or maintained)? Start > ☐ yes ☐ no
Specify where (shop floor, warehouse, client/customer site, parking lot, etc..).

8. Did the accident/illness happen outside the Province of Ontario? ☐ yes ☐ no
If **yes,** where (city, province/state, country).

9. Are you aware of any witnesses or other employees involved in this accident/illness? ☐ yes ☐ 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? ☐ yes ☐ no
If **yes,** please provide name and work phone number

11. Are you aware of any prior similar or related problem, injury or condition? ☐ yes ☐ no
If **yes,** please explain

12. If you have concerns about this claim, attach a written submission to this form. ☐ submission attached

D. Health Care

1. Did the worker receive health care for this injury? ☐ yes ☐ 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)**
☐ On-site health care ☐ Ambulance ☐ Emergency department ☐ Admitted to hospital ☐ Health professional office ☐ Clinic
☐ 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:**
☐ Returned to his/her **regular job** and **has not** lost any time and/or earnings. **(Complete sections G and J).**
☐ Returned to **modified work** and **has not** lost any time and/or earnings. **(Complete sections F, G, and J).**
☐ **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
☐ regular work ☐ modified work

2. This Lost Time - No Lost Time - Modified Work information was confirmed by:
☐ Myself ☐ Other
Name Telephone Ext.

F. Return To Work

1. Have you been provided with work limitations for this worker's injury? ☐ yes ☐ no

2. Has modified work been discussed with this worker? ☐ yes ☐ no

3. Has modified work been offered to this worker? ☐ yes ☐ no
If **yes,** was it ☐ Accepted ☐ Declined
☐ 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
☐ Myself ☐ Other
Name Telephone Ext.

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Claim Number

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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)** Start >

- ☐ Permanent Full Time
- ☐ Permanent Part Time
- ☐ Temporary Full Time
- ☐ Temporary Part Time
- ☐ Casual/Irregular
- ☐ Seasonal
- ☐ Contract
- ☐ Student
- ☐ Unpaid/Trainee
- ☐ Other
- ☐ Registered Apprentice
- ☐ Optional Insurance
- ☐ Owner Operator or (Sub) Contractor

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

H. Additional Wage Information

1. Net Claim Code or Amount — Federal ..... Provincial .....

2. Vacation pay - on each cheque? ☐ yes ☐ no — Provide percentage ..... %

3. Date and hour last worked — dd mm yy ☐ AM ☐ PM

4. Normal working hours on last day worked — From ☐ AM ☐ PM To ☐ AM ☐ 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? ☐ yes ☐ no If yes, indicate: ☐ Full/Regular ☐ 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	Commission	Commission	Commission	Commission
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.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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

S	M	T	W	T	F	S
	8	8	8	8	8	

or,

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

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

▶ **Example:** 4 days on, 4 days off, 12 hours per shift, 8 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 Type your name and upload, or print and sign before returning to WSIB.	Telephone Ext.	Date dd mm yy

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

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Worker Name	Social Insurance Number

K. Additional Information

Start >

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