

Please PRINT in black ink

Claim Number
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A. Worker Information					
Last Name		First Name		Social Insurance Number	
Address (number, street, apt., suite, unit)				Telephone ( )	
City/Town		Province	Postal Code		Alternate/Cell Phone ( )
Job Title/Occupation (at the time you were hurt)			Date you started with employer	dd	mm yy
<b>Only check if you are one of the following:</b> <input type="checkbox"/> executive <input type="checkbox"/> elected official <input type="checkbox"/> owner <input type="checkbox"/> spouse or relative of the employer				How long have you been doing this job for this employer?	
Sex <input type="checkbox"/> M <input type="checkbox"/> F				Date of Birth	
Your Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other				Would an interpreter be helpful? <input type="checkbox"/> yes <input type="checkbox"/> no	
Are you a member of a union?		Do you authorize your union to represent you in this claim?		If <b>yes</b> , do you consent to the disclosure of verbal claim file status information to your union representative?	
<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	
Provide your Union Name and Local					

B. Employer Information		
Company/Employer Name		
Address		
City/Town		Province
Your Immediate Supervisor's Name		Postal Code
		Company Telephone ( )

C. Accident/Illness Dates & Details	
<b>1.</b> Date and hour of accident/Awareness of illness dd mm yy <input type="checkbox"/> AM <input type="checkbox"/> PM Date and hour reported to employer dd mm yy <input type="checkbox"/> AM <input type="checkbox"/> PM	<b>2.</b> Who did you report this accident/illness to? (Name & Position) Telephone ( )
<b>3. Area of Injury (Body Part) - (Please check all that apply)</b>	
<input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Eye(s) <input type="checkbox"/> Ear(s)	<input type="checkbox"/> Teeth <input type="checkbox"/> Neck <input type="checkbox"/> Chest
<input type="checkbox"/> Upper back <input type="checkbox"/> Lower back <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis	<input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Elbow <input type="checkbox"/> Right Elbow <input type="checkbox"/> Left Forearm <input type="checkbox"/> Right Forearm
<input type="checkbox"/> Left Wrist <input type="checkbox"/> Right Wrist <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Finger(s) <input type="checkbox"/> Right Finger(s)	<input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Lower Leg <input type="checkbox"/> Right Lower Leg
<input type="checkbox"/> Other:	Are you: <input type="checkbox"/> Left Handed <input type="checkbox"/> Right handed
<b>4.</b> Did the accident/illness happen on the employer's property or work site? <input type="checkbox"/> yes <input type="checkbox"/> no	Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):
<b>5.</b> Did it happen outside the Province of Ontario? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , indicate where (city, province/state, country):
<b>6.</b> Have you hurt this area(s) of your body before? <input type="checkbox"/> yes <input type="checkbox"/> no	<b>7.</b> Do you have any prior related WSIB/WCB claims? <input type="checkbox"/> no <input type="checkbox"/> yes - In Ontario <input type="checkbox"/> yes - Outside Ontario

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**C. Accident/Illness Dates & Details (continued)**

**8.** If you had a sudden type of accident/illness, describe your injury and what happened to cause it (e.g. hurt lower back while lifting a 50 pound box, sprained left ankle when I slipped on a wet floor, used a new cleaner and immediately got a rash). Please indicate the size, weights and names of any objects involved.  
**or**  
 If you had a gradual onset type of injury, describe your injury, the work that you do and what you believe caused your injury/condition.

**9.** When did you first start to have problems with this injury/condition?

**10.** If you did not report this to your employer right away, please tell us the reason why.

**11.** If there were any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, give us their names & positions.

Name	Position
1.	
2.	

**12.** The Workplace Safety and Insurance Act requires your employer to give you a copy of the Employer's Report of Injury/Disease (Form 7).  
 Did you receive a copy of the Form 7?  yes  no

**The Workplace Safety and Insurance Act requires you to give a copy of this report  
(Worker's Report of Injury/Disease - Form 6) to your employer.**

**D. Health Care Information**

**Give your Health Professional your WSIB Claim number.**

**1.** Did you get first aid or care at work  yes  no If **yes**, when dd mm yy and by whom (Name):

**2.** Where did you go for health care, for your injury, outside of work? **(Check all that apply)**

Facility/Hospital (Name & Address)	Date of Visit (dd/mm/yy)		Date of Visit (dd/mm/yy)
<input type="checkbox"/> Nursing Station <input type="checkbox"/> Emergency Department <input type="checkbox"/> Admitted to Hospital		<input type="checkbox"/> Ambulance	
		<input type="checkbox"/> Health Professional Office	
		<input type="checkbox"/> Clinic	

**3.** Were you prescribed any medications/drugs?  yes  no

**4.** Were you referred for any other treatment or tests?  yes  no

**5.** Did you talk to your health professional about going back to regular or modified work?  yes  no

If **yes**, were you given any work limitations?  yes  no

**6.** Did you tell your employer you went for medical treatment?  yes  no

**If no, please tell your employer right away.**

dd mm yy Name  
 If **yes**, when? and to whom? Position

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**E. Lost Time & Return to Work**

**1.** After the day of accident/illness:

I returned to work to my **regular job** and **did not** lose any time or pay.

I returned to **modified duties** and **did not** lose any time or pay.

I **lost time and/or pay** (e.g. regular pay, shift differential, bonuses, premiums, etc.).

    ↳ Date you first lost time and/or pay    

dd	mm	yy
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**2.** If you lost time, have you returned to work?     yes     no

If **yes**    ↳ Date of your return to work    

dd	mm	yy
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 regular work     modified work

If **no**    ↳ Did you discuss return to work with your employer?     yes     no    Does your employer have modified work?     yes     no

**F. Earnings (Do not include overtime here)**

**1.** Rate of pay: \$ \_\_\_\_\_ per  hour     week     other: \_\_\_\_\_

**2.** Usual number of pay hours: \_\_\_\_\_ per  week     other: \_\_\_\_\_

**3.** If you lost time from work after the day of accident/illness, did your employer continue to pay you?     yes     no

**4.** Have you applied for, or did you receive, any other benefits (money) while off work (e.g. EI benefits, sick benefits, social services, insurance, etc.).     yes     no

**5.** At the time of the accident/illness did you work for more than one employer?     yes     no

**G. Declarations and Signature**

By signing below, you are claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. When you make a claim for benefits, you must consent to disclose your functional abilities information. Your consent allows your health professional to release information about your functional abilities directly to your employer in addition to the WSIB.

**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.**

Signature	Date (dd/mm/yy)
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If you are under the age of 16, your parent or guardian, must authorize the release of the functional abilities information.

Signature	Relationship:	Date (dd/mm/yy)	Telephone (    )
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Personal information about you will be collected throughout your claim under the authority of the Freedom of Information and Protection of Privacy Act and will be used to administer the Workplace Safety and Insurance Act, 1997, your claim and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax receipts and is collected under the authority of the Income Tax Act. Information may only be disclosed to the employer, external medical, vocational, and safety agencies, external payment and service providers, researchers, and others as authorized by the Workplace Safety and Insurance Act and the Freedom of Information and Protection of Privacy Act. Your name and telephone number may be disclosed to third party researchers conducting satisfaction surveys and focus groups. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.

A more detailed **PRIVACY STATEMENT** for workers may be found at [www.wsib.on.ca](http://www.wsib.on.ca) or by calling toll free at 1-800-387-5540.

