Employer's report of injury/disease (Form 7)

Reference guide for employers

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Employer reporting obligations

What are my reporting obligation and when should I complete this report?

Employers must report a work related accident/ illness to the Workplace Safety and Insurance Board (WSIB) if they learn that a worker requires health care and/or

- absent from regular work
- earn less than regular pay (eg.working fewer hours)
- requires modified work at less than regular pay

Reporting is also required if, following the date of the work related accident/illness, the worker does not receive health care but requires modified work at regular pay for more than seven calendar day.

The law requires you to complete this form within 3 calendar days after learning of your reporting obligation as a result of a work related accident/ illness. The completed form has to be received by the WSIB within 7 business days after you learn of your reporting obligation. Do not delay completing and sending the form to the WSIB in Toronto. Send the completed Form 7 by mail or fax

Mail: Workplace Safety and Insurance Board 200 Front Street West, Toronto, ON M5V 3J1

Fax Local: (416) 344-4684 Toll-Free 1-888-313-7373

You should also provide a copy of the completed form to the worker and keep a copy for your records.

Consequences of not meeting your reporting obligations

The WSIB will charge a penalty of $250 for each of the following:

- late submission of this report
- incomplete information
- failing to provide a copy of the completed Form 7 to the worker
- reporting on a version of this form that the WSIB has not approved

These can be multiple fines. For example: If the Form 7 is submitted late and incomplete, the fine would be $500.

Individuals may be liable, on conviction, to a fine of up to $25,000 or up to 6 months in jail. A corporate entity, if convicted, may be fined up to

$100,000.

The employer is required to take every reasonable effort possible to obtain the information requested on the Form 7 and complete and submit it within the allotted time period. If complete information is not possible to obtain within the allotted

time period, submit the Form 7 along with an explanation of what is missing and what is being done to obtain it

What does WSIB consider health care?

Health care includes

- services provided at hospitals and health facilities
- services that can only be provided by one of the following health care professionals: chiropractor, physians, physiotherapist, registered nurse (exteneded class), or dentist

You should complete this report if dentures, glasses and/or artificial appliances (e.g., prosthetic arm) were damaged while being worn in a work related accident

What does WSIB consider first aid?

First aid is the one-time treatment or care and any follow-up visit(s) for observation purposes only. First aid includes, but is not limited to:

- cleaning minor cuts, scrapes or scratches
- treating a minor burn
- applying a cold compress, cold pack or ice bag
- applying a splint
- changing a bandage or a dressing aftera follow-up observation visit

Do I have to report first aid treatment?

It is necessary to complete this report for first- aid-only injuries handled by an in-house/worksite health care professional or trained first-aider.

However, the law requires that you must keep a record of all first aid details

Need help with this form?

If you need assistance completing this form, contact the WSIB at 416-344-1000 or 1-800-387-0750.

A complete list of contact numbers for all WSIB offices is on the back cover of this guide.

The Office of the Employer Adviser is also available to provide assistance. You can contact them directly, toll-free at 1-800-387-0774.

Heading area

① WSIB mailing address and fax numbers

All claims are established through the Toronto office of the Workplace Safety and Insurance Board. To avoid delays, fax or mail completed Form 7s to the Toronto Office.

WSIB CSPAAT
Mail To: 200 Front Street West Toronto ON M5V 3J1
OR Fax To: 416-344-4684 OR 1-888-313-7373
Please PRINT in black ink
7 Employer's Report of Injury/Disease (Form 7)
Claim Number
A. Worker Information
Job Title/Occupation (at the time of accident/illness - do not use abbreviations) | Length of time in this position | Social Insurance Number

Mail: Workplace Safety and Insurance Board, 200 Front Street West, Toronto ON M5V 3J1

Fax: (416) 344-4684 or 1-888-313-7373

② Claim number

Once the claim is established, the WSIB will send the employer the claim number. If the employer already has the claim number when completing the Form 7, it should be included on all pages.

If you include attachments to the Form 7, write the worker's name and claim number (if known) on all pages.

③ Please print in black ink

If you complete the Form 7 by hand, please print neatly and use black ink. As most forms are faxed, printing in black ink makes them easier to read.

WSIB CSPAAT
Please PRINT in black ink
7 Employer's Report of Injury/Disease (Form 7)
Claim Number
Worker Name | Social Insurance Number
C. Accident/Illness Dates and Details (Continued)

4 Worker name, claim number and social insurance number

On the top of each page, you will find a space to provide the worker's name, social insurance number and claim number (if known). Please provide it here as this helps to make sure the pages remain together as they are processed.

Section A – Worker information

This information is required to establish the worker's claim.

WSIB ONTARIO CSPAAT
Mail To: 200 Front Street West Toronto ON M5V 3J1
OR Fax To: 416-344-4684 OR 1-888-313-7373
Please PRINT in black ink
7 Employer's Report of Injury/Disease (Form 7)
Claim Number
A. Worker Information
Job Title/Occupation (at the time of accident/illness - do not use abbreviations) A4
Length of time in this position while working for you A5
Social Insurance Number A2
Please check if this worker is a: executive A7 elected official owner spouse or relative of the employer
Is the worker covered by a Union/Collective Agreement? yes no
Worker Reference Number
Worker Name
Address (number, street, apt., suite, unit) A1
City/Town Province Postal Code
Worker's preferred language English French Other
Date of Birth dd A3 yy
Telephone ( )
Sex M F
Date of Hire dd mm yy A6
B. Employer Information

A1 Worker name and address (number, street, apt./unit city/town, province, postal code), telephone

Give the worker's complete name, last name followed by first name and their current, and complete home address.

This information is placed so it can be seen in the window of an envelope. This will make it easier for you to mail a copy to the worker.

A2 Social insurance number

The worker's 9-digit social insurance number is required to meet WSIB reporting obligations and requesting it is authorized under the Income Tax Act

A3 Date of birth

Give the worker's date of birth Date/Month/Year DD/MM/YY (eg. 26/01/59)

A4 **Job title/cccupation** (at the time of accident/illness – do not use abbreviations)

Give the worker's job at the time the accident/illness occurred. Give us the name of the job the worker was doing when injured, even though it may not be the worker's regular job.

Example: Normally, Linda is a welder, but was temporarily working as a shipper/receiver in the warehouse when injured.

In this case you would give the job title of shipper/receiver.

A5 Length of time in this position while working for you

Give the length of time (in years, months or weeks) that the worker has been performing the job he/she was injured at.

Example:The worker may have been employed by your firm for 7 years, but, at the time of injury, the worker had only been doing that job for 2 years, then answer 2 years.

A6 Date of hire

Give the date the worker became an employee of your firm. If the worker has been hired in the past, (e.g. seasonal or temporary worker), provide the most recent date of hire.

A7 Please check if worker is a:

Executive officer, elected official, orwner or spouse or relativeof the employer

This will not apply to most workers. However, you should know that to be covered in case of injury/illness under the Workplace Safety and Insurance Act, these people would likely need to have optional insurance. If you are unsure of the status, check the one you think is correct and the adjudicator will follow-up with you. Do not delay sending in the form even if you are.

DEFINITIONS
Executive:

- has been delegated the authority to act independently on behalf of the organization
- is responsible for the overall direction and control of the company's operations or financial affairs
- exercises a broad scope of authority to make decisions or formulate policies for the organization as a whole, rather than the authority that is strictly limited to a specific branch or division
- has the ability to bind the organization

These may include anyone of the members of the Board of Directors, including the position of Chair, Vice-Chair, President, Vice-Presidents and Chief Executive Officers, Corporate Secretary, Treasurer, or Director in a limited company, or General Manager or Manager

designated an officer by by- law or resolution of the Directors. (For more detailed information about Executive Officers, please refer to WSIB Operational Policy 12-03-03. The WSIB Operational Policy Manual can be found at the WSIB website at www.wsib.ca.

Elected Official:

- has been elected to the position
- has been temporarily appointed to an elected position
- is a member of the governing board, either appointed or elected
- or the equivalent thereof

(For more detailed information about Elected Official, please refer to WSIB Operational Policy 12-03-03. The WSIB Operational Policy Manual can be found on the WSIB website at wsib.ca

Owner – is listed as the owner/proprietor of the business.

Spouse or Relative of the Employer –may be listed as an Executive Officer. For further information or clarification, contact the WSIB at 416-344-1000 or 1-800-387-0750.

WSIB ONTARIO CSPAAT
Mail To: 200 Front Street West Toronto ON M5V 3J1
OR Fax To: 416-344-4684 OR 1-888-313-7373
Please PRINT in black ink
7 Employer's Report of Injury/Disease (Form 7)
Claim Number

A. Worker Information
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: executive | elected official | owner | spouse or relative of the employer

Worker Name
Address (number, street, apt., suite, unit)
City/Town | Province | Postal Code

Is the worker covered by a Union/Collective Agreement? yes | no (A10)
Worker Reference Number (A8)
Worker's preferred language English | French | Other (A11)
Date of Birth dd mm yy
Telephone ( )
Sex (A9) M | F
Date of Hire dd mm yy
Fold here for #10 envelope

B. Employer Information

(A8) Worker reference number

The employer may wish to record the firm's employee identification number (e.g., the worker's payroll number) in this space. The WSIB does not require this number. It is here for the employer's own internal tracking purposes

Mining companies, including contractors doing mining work, may enter the worker's *Miner's Certificate Number* here

(A10) Sex

Check M (male) or F (female)

A9 Is the worker covered by a Union Collective Agreement?

Check 'yes' if this worker is a member of a recognized union/association that has a negotiated collective agreement with your firm. The name/local is not required now. We will request it if needed.

A11 Worker's preferred language

Check (√) which language preference applies to this worker. Unless you indicate that the worker prefers French services, all services will be provided in English. If the worker speaks neither English nor French, specify the worker's spoken language. The WSIB has the ability to communicate with workers in many languages.

Section B – Employer information

B. Employer Information

Fold here for #10 envelope

Trade and Legal Name (if different provide both) (B1)

Check one: Firm Num (B3) OR Account Number — Provide Number

Mailing Address (B2)

Class/Subclass

NAICS Code

City/Town

Province

Postal Code

Telephone

Description of Business Activity

Does your firm have 20 or

FAX Number

B1 Trade and legal name

Give the name of the employer. The Trade Name is the commonly used name; the Legal Name is what appears on legal documents. If they are different, provide both. This helps to establish and administer the claim, avoid delays and minimize postal errors.

Example: The company Trade Name is "Sam's Pizza" and the Legal Name is "123456 Ontario Inc." So, give both names.

B2 Mailing address, city/town, province, postal code, telephone and fax number

Give the full mailing address, **including postal code**, of the employer. The WSIB will send all correspondence **for this claim** this address

B3 Check one:

Check (√) either Firm Number or Account Number and give the number in the space provided.

This number is used to assign the claim to the correct employer. The WSIB can establish a claim using either number, but the Firm Number is preferred.

Firm Number

A six to eight digit number (may have numbers and letters) used to identify and track accident costs for both Schedule 1 and Schedule 2 employers and to bill Schedule 2 employers.

For **Schedule 1 employers**, this number appears on the top right corner of your Premium Remittance Statement.
For **Schedule 2 employers**, this number appears on the top left corner of your Monthly Statement.

Account Number

A seven-digit number (numbers only) used to identify and bill Schedule 1 employers. **This number appears on the top right corner of your Premium Remittance form.**

Many employers have several account and/or firm numbers, depending on the type of business they conduct. Providing the correct number that is associated with this worker will ensure that the claim is charged to the correct employer, minimizing problems in the future.

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 (B4)	NAICS Code (B5)
City/Town	Province	Postal Code	Telephone
Description of Business Activity (B6)		Does your firm have 20 or more workers? (B7) ☐ no	FAX Number
Branch Address where worker is based (if different from mailing address - no abbreviations) (B8)			
City/Town	Province	Postal Code	Alternate Telephone

Class/subclass and NAICS code

All claims will report under a Class/Subclass and NAICS code. This is adapted from the North American Industry Classification system (NAICS), a standard structure by which Statistics Canada and the Canada revenue Agency classify all employers across Canada.

B4 Class/subclass

The WSIB classification structure is comprised of 34 industry classes and subclasses which contains the 6-digit NAICS codes

Example: **Class/Subclass:** G1 **Description:** Building Construction

If you have been assigned more than one Class/Subclass, select the Class/Subclass of the business activity the injured person was engaged in when they became ill or were injured.

B5 NAICS code

As an employer, you have been assigned at least one NAICS code, some employers may be assigned more than one. If you have been assigned more than one NAICS code, select the NAICS code of the business activity the injured person was engaged in when they became ill or were injured.

Example: NAICS code: 236110 - Residential Building Construction

If the injured person was engaged in an ancillary (incidental) activity (e.g. administration) and you cannot assign the work performed to a specific NAICS code, assign the NAICS code that represents the highest proportion of your annual assessable insurable earnings.

For more information about your Firm Number, Account Number, Class/Subclass, and NAICS codes, contact the WSIB general number at (416) 344-1000 or toll free 1-800-387-0750

B6 Description of business activity

Please provide a brief yet specific description of what your business does.

Examples:

- retail shoe store
- bicycle repair shop
- automotive manufacturing

B7 Does your firm have 20 or more workers?

At the time of the worker's accident/illness, please indicate if your firm employed 20 or more workers. This helps the WSIB to properly deliver the right service to the employer.

B8 Branch address where worker is based

(if different than mailing address – no abbreviations)

Ensure that you provide the address of the location, branch, plant or department where this worker reports to, if it is different from the mailing address. This information helps us assign the claim to the correct WSIB office and service delivery team. Claim related mail will not go here; it goes to the "Mailing Address".

The Alternate Telephone allows you to provide us with the phone number at the Branch Address location.

Example:

- the company's head office may be in Ottawa, but the branch office/location where this worker reports is in Kingston. So, give the Kingston office address here.
- For construction, give the nearest construction branch office to which the worker reports, and not the actual worksite location

Section C – Accident/illness dates and details

The information in this section provides us with the important details surrounding the accident/illness. The WSIB uses these details to help make the initial entitlement decision on a claim. This information is also used by us to develop prevention strategies that will reduce workplace injuries/illnesses.

C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness — dd mm yy (C1) AM PM

Date and hour reported to employer — dd mm yy AM PM

2. Who was the accident/illness reported to? (Name & Position) (C2)

Telephone ( ) Ext.

3. Was the accident/illness: (C3)
- Sudden Specific Event/Occurrence
- Gradually Occurring Over Time
- Occupational Disease
- Fatality

4. Type of accident/illness: **(Please check all that apply)** (C4)
- 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)** (C5)
- Head, Face, Eye(s), Ear(s), Other
- Teeth, Neck, Chest
- Upper back, Lower back, Abdomen, Pelvis
- Left / Right: Shoulder, Arm, Elbow, Forearm
- Left / Right: Wrist, Hand, Finger(s)
- Left / Right: Hip, Thigh, Knee, Lower Leg
- Left / Right: Ankle, Foot, Toe(s)

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

C1 Date and hour of accident/awareness of illness

Give the date and time that the accident/ illness occurred. This may be either:

- a specific date/time such as in the case of an incident like a trip and fall; or
- the date/time when the worker states he/ she first started to notice a problem.

Date and hour reported to employer

Give the date and time that the worker first reported the accident/illness to an employer representative. An employer representative may include:

- first aid attendant or officer
- immediate supervisor or site official
- time office or dispatcher, or
- other employer official

C2 Who was the accident/illness reported to?

(Name and Position) Telephone

Give the name of the individual to whom the worker first reported the accident/illness. Remember to include this individual's position with the company as well as the telephone contact number (including extension) – if different than the number provided under Section B - Employer Information

C3 Was the accident/illness:

Indicate how the accident/illness occurred

Sudden Specific Event/Occurrence

- a chance event is an identifiable and unintended event. You can see what causes the injury (e.g. falling objects, slips, trips, cuts). The injury is an expected result of something identifiable and unintended (e.g. a box falling from a shelf hitting and breaking worker's arm).
- An unexpected result of working duties from particular movements (e.g. lifts, pulls, reaches, etc…) that causes sudden and noticeable pain. (e.g. a warehouse picker pulling a stuck box from a shelf causing pain in the worker's shoulder).
- A willful and intentional act, with the deliberate act not by the worker, but by someone else, that results in an injury (e.g. fights between co-workers, police officer assaulted by an individual, sales clerk assaulted by a thief during a robbery, etc…).

Gradually Occurring Over Time

- This is an onset of an injury/condition that has emerged over a period of time (hours, days or longer), and where the worker is unable to recall an exact point when the injury/condition or pain started
- There is no identifiable event. The worker may have started to notice pain or discomfort while performing their normal duties. (e.g. full-time cashier continually scanning products with the left arm and begins to experience pain in the left elbow)

Occupational Disease

Choose this option only if it is clear that there is an occupational disease as outlined below.

An accident/illness in which a disease

- results from an exposure (sudden or over time) to a substance in the workplace
- is peculiar to or characteristic of a particular industrial process, trade or occupation
- in the opinion of the WSIB, requires the worker to be removed from the workplace (temporarily or permanently) as exposure to a substance may be a precursor to an occupational disease
- is mentioned in Schedule 3 or 4 of the Workplace Safety and Insurance Act

Fatality

An accident/illness that results in the death of a worker

C4 Type of accident/illness:

(Please check all that apply)

Check (√) the type (or category) of accident/ illness. If the type of accident is not on the list provided, please check 'Other' and give a description. The WSIB uses this information to help create and deliver prevention programs

C5 Area of injury (body part):

(Please check all that apply)

Check (√) all the areas of injury. Some areas may not be listed here. If not listed, check (√) 'Other' and give a description in the space provided. Remember to include 'Left' or 'Right' if applicable.

The areas provided are general physical locations of the body. This information is also requested on the Health Professional's Initial Report (Form 8) and the Worker's Report of Injury/Disease (Form 6) and will be used by the adjudicator in the decision- making process.

Ear(s) Pelvis Elbow Forearm Finger(s Knee Lower Leg Toe(s)
Other

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.**

C6

0007A (07/05) **A guide to complete this form is available at** www.wsib.on.ca Page 1 of 3

C6 Describe what happened to cause the accident/illness and what the worker was doing at the time…

Give a written account outlining the details of the cause of the accident/illness as reported and reviewed through your accident investigation process. This is the "story" of what happened. Give as much detail as possible. If needed, use a separate sheet to provide details and include it as an attachment to this Form 7. Please note that any attachment to the Form 7 is considered to be part of the Form 7 and a copy is to be given to the worker.

Examples:

- the worker slipped, fell or tripped
- the worker was struck or bumped into
- the worker twisted her left ankle or left knee

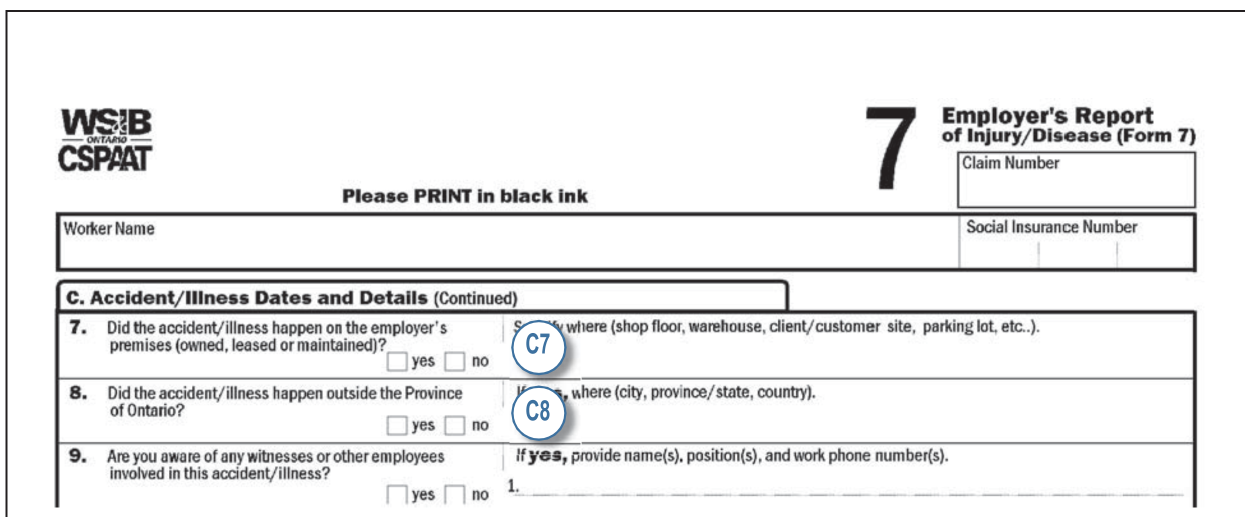
If you are not aware of a specific accident/ incident that caused the injury/illness, describe what the worker was doing and the effort involved when the onset of pain, or when the disease, was first noticed.

Examples:

- the worker was in an awkard position
- the worker was doing strenuous work
- the work was repetitive
- the worker was not aaccustomer to

Include any details about the work area, materials or equipment used, other people involved or any detail that you believe is important.

If your firm has a physical demands analysis (PDA) of the work the worker was doing at the time of the onset, please attach a copy to this Form 7. If you would like to obtain a PDA form, along with examples on how to complete it, please visit our website at wsib.ca under "Employer Forms" and download "Physical Demands Information Form (Form #2830A)".


WSIB ONTARIO CSPAAT

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

Please PRINT in black ink

Claim Number

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)? ☐ yes ☐ no — S... where (shop floor, warehouse, client/customer site, parking lot, etc..). C7

8. Did the accident/illness happen outside the Province of Ontario? ☐ yes ☐ no — If ... where (city, province/state, country). C8

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.

C7 Did the accident/illness happen on the employer's premises (owned, leased or maintained)?

Check (√) here if the accident/illness occurred, or did not occur, on property that is owned, leased or maintained by the employer.

If yes, please indicate where on your premises it did occur

If no, give the actual location of where it happened. The adjudicator may contact you for more details

Example:

- yes – assembly line, shop floor, warehouse storage area, parking lot.
- no – delivery driver making a delivery to a restaurant slips on the greasy kitchen floor; provide the name of the restaurant.

C8 Did the accident/illness happen outside the Province of Ontario?

Check 'yes' if the accident/illness occurred outside of Ontario. If yes, the worker may have the choice of claiming benefits either in Ontario or where it happened.

If claiming in Ontario, the worker must sign an election form. This question prompts the WSIB to send an election form to the worker at the time of claim registration, avoiding potential delays. Although a claim can be established, a decision cannot be made until the election form has been received and approved by the WSIB. The worker has three months from the day of accident to submit the election form

Example: An Ontario truck driver has a motor vehicle incident in Alberta. The worker has the choice to claim in Alberta or Ontario, and uses the election form to indicate that choice

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. (C9)

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 (C10)

11. Are you aware of any prior similar or related problem, injury or condition? ☐ yes ☐ no — If **yes,** please explain (C11)

12. If you have concerns about this claim, attach a written submission to this form. ☐ submission attached (C12)

D. Health Care

C9 Are you aware of any witnesses or other employees involved in this accident/ illness?

Check yes if:

- Anyone saw what happened
- Other employees were involve in the worker's accident/illness
- Anyone has knowledge of the accident/illness

If yes, give the name(s), position(s) and work phone number(s) in the space provided.

For injuries that occurred gradually over time, it may be helpful to provide the name of employees who may be aware of the worker's condition

As part of the claim decision-making process, the WSIB may need to speak with them.

C10 Was any individual, who does not work for your firm, partially or totally responsible for this accident/illness?

Check 'yes' if any individual(s), not employed by your firm, had any part in this worker's accident/illness. If yes, write the name(s) and work phone number(s) in the space provided.

As part of the decision-making process, the WSIB may need to speak with them. The WSIB will investigate and review if we should transfer the costs associated with this claim, either in whole or in part, from your firm to the other responsible party.

Example:

John is making a delivery of produce at Joe's Fast Food Restaurant. John slips, injuring his right ankle, due to grease on the restaurant kitchen floor. Joe's Fast Food Restaurant may be responsible for all or part of the costs associated with John's claim. (This only applies to Schedule 1 employers.)

C11 Are you aware of any prior similar or related problem, injury or condition?

Check 'yes' if you are aware if this worker has had any prior similar problems, injuries or conditions that may be related or contributing to the worker's current reported injury/condition. In the space provided, write a brief outline of what you believe they are. The WSIB may investigate further to determine if the prior problem, injury or condition has any impact on the worker's present problems. If you need more space, use a separate sheet and include it as an attachment to this Form 7.

C12 If you have concerns about this claim, attach a written submission to this form.

The employer may have concerns regarding the accident/illness. If so, please attach a separate submission to this Form 7 and check (√) here if you are doing so. Any attachments to the Form 7 are considered to be a part of the Form 7, and copies are to be given to the worker.

Please include the worker's name and social insurance number or the claim number (if available) on all pages being attached.

This is your opportunity to provide any further information not already requested in the form

Provide supporting information if you have reason to doubt this claim. The WSIB will investigate further before making a decision. If you do not provide supporting information about why you doubt the claim, a decision will be made with the existing information on the file

Section D – Health care

The worker has the right to make the initial choice of health professional. A health professional includes chiropractor, physician, physiotherapist, registered nurse (extended class) or dentist. For further information see the WSIB Operational Policy 17-01-03 – Choice and Change of Health Professional.

At the time an accident/illness occurs, the employer is responsible for the initial transportation of the worker (if needed) to a facility for health care or treatment. The employer is also responsible for paying the cost of transportation (e.g. ambulance, taxi, etc).

D. Health Care

1. Did the worker receive health care for this injury? yes / no — If **yes**, wh... (D1) dd mm yy

2. When did the employer learn that the worker received health care? (D2) 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: (D3)

Name, address and phone number of health professional or facility who treated this worker (if known) (D4)

D1 Did the worker receive health care for this injury?

Check 'yes' if this worker was provided with any health care as a result of the accident/ illness

If yes, please indicate when the health care took place. This also includes any health care given to this worker at the worksite. Do not confuse this with first aid

First aid refers to any care provided to a worker that could be given by a trained first-aider (e.g. washing a wound, applying a dressing, etc…) even if done by an in- house health professional. If the injury only requires first aid, a Form 7 does not have to be completed and sent to the WSIB. However, under the Occupational Health and Safety Act, the employer is required to keep a record of any first aid administered.

Health care refers to professional services provided by any of the following registered health care professionals: chiropractor, physician, physiotherapist, registered nurse (extended class) or dentist. Health care can be received from a hospital, other facility (emergency department, walk-in clinic, health professional office, etc…) or the worksite. A Form 7 must be completed and submitted if the worker got health care.

The employer should make every reasonable effort possible to obtain this information. If this information is not possible to obtain, please provide an explanation of what is being done to get it.

D2 When did the employer learn that the worker received health care?

Give the date when the employer was first advised, or made aware, that the worker got health care for the reported accident/illness.

The reporting obligation for the employer begins once they learn that the worker got health care for the work related accident/ illness.

D3 Where was the worker treated for this injury?

(Please check all that apply)

If known, check (√) the place(s) where the worker received health care for his/her injury/illness. (Definitions provided below). Please check (√) all that may apply.

On-site health care

This refers to any health care provided at the workplace or worksite, where the accident/ illness happened.

Ambulance

If an ambulance was called. This could indicate how serious the accident/illness is and will trigger special attention by the WSIB. If an ambulance is called on the day of accident/illness, the employer is responsible for paying the cost.

Emergency department

This may be provided within a hospital or a specialized emergency facility outside of a hospital. Please give the name and location of the hospital or emergency facility.

Admitted to hospital

The worker may have been admitted to a hospital for an overnight stay. This could indicate how serious the accident/illness is and will trigger special attention by the WSIB. Please give the name and location of the hospital.

Health professional office

Many health professionals have their own private practice and this refers to that health professional's independent office.

Clinic

This refers to a walk-in clinic or a facility where several health professionals provide health care. The clinic may be a multi- disciplinary clinic with several different types of health professionals.

Other

If the worker sought health care from anyone not listed above, please indicate it here (e.g. Nursing Station).

D4 Name, address and phone number of health professional or facility who treated this worker (if known)

In the space provided, print the name and contact details of who provided the worker with this health care.

Section E – Lost time – no lost time

The employer is responsible for paying the worker's full wages for the day of the accident/illness. Following that day, any lost time or reduction in wages that results from the accident/illness must be reported to the WSIB. The worker may be entitled to receive WSIB loss of earnings benefits.

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).** E1

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 E2 Telephone ( ) Ext.

F. Return To Work

E1 Please choose one of the following indicators.

You must choose one and only one of the options and complete the remainder of the form as indicated

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).

- In this situation, the worker has returned and continued to do his/her regular job/work duties without requiring any changes or accommodations to the work or the workplace after the day of accident/ illness
- The worker has not lost any time from work beyond the day of accident/illness and there has been no reduction or change in wages or earnings.

Returned to modified work and has not lost any time and/or earnings. (Complete sections F, G and J).

- In this situation, the worker has returned to work after the day of accident/illness. Changes or accommodations were required to the work or the workplace in order for the return to work to occur
- The worker may be continuing with modified work or, following a period of modified work, is now back to his/her regular job/work duties.
- The worker has not lost any time from work beyond the day of accident/illness and there has been no reduction or change in wages or earnings.
- This situation also includes any temporary changes, alterations or modifications to the worker's shifts or schedule

Example:

- A warehouse worker sustains a shoulder injury and returns to work with no above shoulder level work for one week
- A delivery driver returns to work with no driving for two days, and then resumes regular driving duties.

Has lost time and/or earnings. (Complete ALL remaining sections).

Please check (√) this box if any of the following apply:

The worker is absent from work beyond the day of accident/illness. This absence may be for part of a day, an entire day or more. This includes an absence for a medical appointment or health care

treatment for the injury. The worker may have returned to work after the absence

The worker has experienced a reduction in earnings. This reduction may be the result of working at a lower paying job, losing a shift premium or production bonus, or other similar circumstances.

The worker is losing time from work, but the employer continues to pay the worker.

The worker returned to work, but was unable to continue

Provide the date that the worker first lost time and/or earnings. If you, as the employer, are not sure if this worker will lose time or earnings, you should make every reasonable effort to obtain this information. If you are unable to obtain this information, please provide an explanation of what is being done to get it.

If the worker returned to work, before the submission of the Form 7, give the return to work date. Indicate if the return to work was to regular work or modified work.

E2 This lost time – no lost time – modified work information was confirmed by:

In many situations, the individual completing the Form 7 may not have direct or first hand knowledge of the accident/illness details, lost-time/no lost time, or return to work information. Give the name of the individual who supplied this information as the WSIB may need to contactthem further clarification.

Section F – Return to work

A worker may have work or task limitations as a result of the work related accident/illness. To assist you in helping the worker get back to work safely, you will need to be aware of those work/task limitations. You can use this information to set up modified work that accommodates the worker's limitations.

To obtain work/task limitations, you can give a copy of the WSIB's "Functional Abilities Form for Timely Return to Work" Form #2647 (FAF) to the worker. Have the worker get it completed by their health professional and a copy returned to you.

Getting the FAF

- Fax your request to the WSIB at 1-888-313-7373. Include the employer name, address and the number of forms required. Print clearly to avoid postal errors.

Other ways to get work/task limitations are:

- By using your own return to work form; or
- Through a medical/clinical note or report from the health professional.

Please note: The WSIB will only pay for completion of the WSIB "Functional Abilities Form for Timely Return to Work" (FAF). Payments for any other employer supplied forms are the responsibility of the employer.

F. Return To Work

F1 **1.** Have you been provided with work limitations for this worker's injury? ☐ yes ☐ no

F2 **2.** Has modified work been discussed with this worker? ☐ yes ☐ no

F3 **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

F4 Name ______ Telephone ( ) Ext.

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F1 Have you been provided with work limitations for this worker's injury?

Following the receipt of health care, the worker may require work/task limitations due to the injury/illness. Please check if you have been provided with any limitations for the worker

If you have work/task limitations, please attach them to the Form 7.

If no work/task limitations are available, discuss with the worker how to get them and any other concerns the worker may have about return to work.

For further assistance on return to work, you can contact the WSIB at 416-344-1000 or 1-800-387-0750 or visit our website at www.wsib.ca

F2 Has modified work been discussed with this worker?

Check 'yes' here if there has been a discussion about a return to work with the worker This discussion can include any work/tasklimitations, job duties, accommodations or other options to facilitate return to work. Based on the discussion, it should become clear if a return to work is possible.

If no discussion about return to work has taken place, you should arrange with the worker to do so. You should also review what work you may have available and what changes you can make to the worker's duties to accommodate a return to work

F3 Has modified work been offered to this worker?

Check 'yes' if there has been an offer of modified work given to the worker. This offer should be specific with all details clearly understood by everyone.

If yes:

Check (√) to indicate the outcome of the return to work

If declined by the worker, provide the worker and the WSIB with a written copy of the return to work offer.

Providing a written copy is not an obligation, but is a recommended best practice. A written offer establishes and documents what the employer offered. You should be able to demonstrate that the worker received a copy of the written offer. Provide the WSIB a copy as this gives the adjudicator a clear idea of the modified work offered and assists in further decision-making.

If you encounter difficulties in the return to work process, please contact your adjudicator.

F4 Who is responsible for arranging the worker's return to work?

In many situations, the person completing the Form 7 may not be the person directly responsible for arranging the worker's return to work. Should problems or issues arise during

the return to work process, the adjudicator must be able to contact the person responsible for arranging the return to work. Otherwise, the return to work process and decisions surrounding return to work can be delayed.

Please give the name of the person responsible for setting up the return to work and the phone number if different from the phone number provided under Section B - Employer Information

If the person responsible for setting up the return to work is an external consultant or representative, provide the written authorization of representation for them to act on the employer's behalf.

Section G – Base wage/employment information

This information is requested in all claims. The worker's employment type and basic rate of pay should be readily available. For no lost time claims, we do not expect the employer to make elaborate calculations (e.g. commission sales, piecework) regarding rate of pay. In lost time claims, we expect the complete rate of pay information

When a claim changes from no lost time to lost time, obtaining the worker's complete earnings information may take time. This change of claim status may occur several weeks, months or years after the claim is originally allowed. The adjudicator must be able to issue payment in these claims. The worker's employment type and basic rate of pay can be used to pay benefits on a temporary basis until the employer has provided the complete earnings information to the WSIB.

WSIB ONTARIO CSPAAT

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

Please PRINT in black ink

Claim Number

Worker Name | Social Insurance Number

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

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

- ☐ 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

G1

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

H. Additional Wage Information

G1 Is this worker

(Please check all that apply)

Indicate the worker's employment status by checking the appropriate box(es). A worker may have more than one status.

You may be aware that your employee also works for another employer. If this is the case, also check the “Other” box and explain.

Examples:

The worker may be a:

- Permanent full time worker
- Temporary full time worker on a contract
- Permanent full time woker is a register apprentice

DEFINITIONS
Permanent (Full-Time or Part-Time)

This, also known as regular, is when a worker

- Has been hired by the employer to work 52 weeks a year with no seasonal or cyclical layoffs
- Has no set termination date
- Has a set number of hours worked per week

Examples:

Permanent Full-Time – Bob has worked continuously for over 10 years for the ACME Company, Monday to Friday, 40 hours per week

Permanent Part-Time – Jane has been a cashier with The A & B Supermarket Ltd. for the past 7 years, normally scheduled to work 15 hours per week.

Please note: A worker in Permanent employment, whose earnings vary from day to day or week to week due to irregular hours or method of payment, is also considered to be in “Irregular” employment.

Temporary (Full-Time or Part-Time)

This is a worker who has a set number of hours worked per week and:

- is hired for a specific period of time, or
- has a termination notice (e.g. contract workers), or
- is hired for a temporary period through a union hall, or
- there is no guarantee of ongoing employment.

Temporary workers may include temporary agency workers (workers who work for an agency that hires them out to other employers).

Examples:

Temporary Full-Time – Judy is hired as a full-time executive assistant for a one year period to cover for an employee off on maternity leave

Temporary Part-Time – Jasper has been hired to work as a security guard for 4 hours per day for a one-time special event (3-day music festival).

Casual/Irregular

This is when a worker has no set schedule or hours of work. This would also include “On-Call” workers

Example: Sara works as a waitress for Black’s Bar. There is no set schedule for her work and she only knows from week to week her upcoming hours and shifts. There is no minimum guarantee of hours.

Seasonal

Seasonal, or cyclical workers, are employees hired to work for certain times of the year and with periods of layoff expected.

Example: Martin is hired to work at a large amusement park for the summer season only.

Contract

This is when a worker is hired to work at a specific job at a specific rate of pay and usually for a specific period of time.

Example: Terry has been hired on a three-month contract to work as a data entry operator for 24 hours a week to clear-up a backlog of invoices

Student

A student is defined as

- a community college student
- a high school student
- a night school student
- a university student

Secondary school students who are registered in Ministry of Education work education programs and who are placed with an employer (placement host) to gain practical work experience, and who are not paid by the placement host, have WSIB coverage during the placement. The Ministry of Education provides coverage. These students, also referred to as pupils, are deemed to be workers under the *Education Act.*

Examples:

- Simone is a college student working part- time after school at a local restaurant
- Adrian is a high school student in a co-op program at the local museum.

(For more detailed information about students, please refer to WSIB Operational Policy 12-04-07. The WSIB Operational Policy Manual can be found on the WSIB website at **www.wsib.ca**).

Unpaid/Trainee

Individuals who are placed by a training agency (i.e. Goodwill, March of Dimes) with a host employer to obtain skills and experience, but are not paid by that

employer, are called Unpaid Trainees and/or Learners. Although not under a contract of service or apprenticeship, they are considered workers and are entitled to benefits if injured.

If an accident/illness does occur, the host employer is responsible to report this to the WSIB. When reporting, use the entry level pay for the job being done. The host employer would not be responsible for the costs associated with the claim

Example: Anthony, who has a learning disability, has been placed by the Ontario Works Program with a local repair shop to gain experience in small engine repair.

Registered Apprentice

An apprentice is a person registered under the *Trades Qualification and Apprenticeship Act* (specified construction trades) or the *Apprenticeship and Certification Act* (all other trades), who has signed a contract of apprenticeship for training and instruction in a trade, through or from an employer.

Please provide the "Registered Apprentice Number" in the space provided beside "Other"

Example: Frank is employed by ABC Masonry Ltd. as an apprentice stone mason.

Optional Insurance

Check (√) this box to indicate if the person who is injured has optional insurance coverage. For more information on Optional Insurance, please refer to Fact Sheet #0121A

"Optional Insurance", available on our website wsib.ca in the Reference tab, under "General".

Optional insurance may be applied for by:

- owner/operators (as previously defined)
- executive officials
- elected officials

Example: Meileen is a physician in her own practice and has applied for optional insurance coverage

Owner Operator / (Sub) Contractor

Check this box if the following situation applies to you:

The following are considered to be an owner/operator of a business:

- independent operator
- sole proprietor

- a partner in a partnership

These people may apply to purchase optional insurance coverage under the *Workplace Safety and Insurance Act*.

or

Individuals who are contracted or commissioned to do work and perform the work personally. If either party considered the work arrangements to be a business relationship of purchaser/ independent operator, both are strongly encouraged to obtain a ruling on the relationship.

The WSIB reserves the authority to determine, on a case by case basis, whether the individual is a worker, or in fact, an owner operator, (sub) contractor or independent operator.

If you need assistance with this call the WSIB at 416-344-1000 or 1-800-387-0750. The phone numbers for each District office is located on the back cover of this guide.

WSIB ONTARIO CSPAAT

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

Claim Number

Please PRINT in black ink

Worker Name | Social Insurance Number

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

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

- 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 $ G2 per hour day week other

H. Additional Wage Information

G2 Regular rate of pay

Provide the worker's normal/regular gross rate of pay at the time of the accident/illness here. This should not include any bonuses, premiums, differentials, etc.

Examples:

- $9.00 per hour
- $100.00 per day
- $450.00 per week
- $35,000 per year

If the rate of pay is difficult to provide (e.g. commission sales, piecework, etc.), we do not expect the employer, if there is no lost time or pay after the day of accident/illness, to make any calculations. Rather, describe the type of pay in the “Other” space and include any base pay, if applicable.

Example: Other – $7.15 per hour + 5% Commission on sales

Section H – Additional wage information

If a worker has lost pay as a result of a work related accident, he/she may be entitled to a loss of earnings (LOE) benefit. The WSIB needs complete and accurate earnings information to calculate loss of earnings for workers.

In certain cases, the benefit rate is recalculated at the 13th week to ensure that the worker’s long term earnings are more fairly reflected (e.g. profit sharing, yearly bonuses, vacation accrual). For further information regarding Short-Term and Long-Term Earnings, see Fact Sheet #0794A – “Determining Average Earnings”, available on our website wsib.ca in the Reference tab, under “General”.

This section has been designed to enable most employers to give wage information. We do appreciate that there are unique situations that cannot be accommodated here. For those employers, we recommend that you contact the adjudicator directly to give the required wage information.

H. Additional Wage Information

1. Net Claim Code or Amount — Federal (H1) — Provincial		2. Vacation pay - on each cheque? ☐ yes ☐ no	Provide percentage (H2) %
3. Date and hour last worked — dd mm yy (H3) ☐ AM ☐ PM	4. Normal working hours on last day worked — From ☐ AM ☐ PM To (H4) ☐ AM ☐ PM	5. Actual earnings for last day worked — $ (H5)	6. Normal earnings for last day worked — $ (H6)

7. Advances on wages:

(H2) Net claim code or amount

The WSIB needs the Federal and Provincial “Net Claim for Exemption” or “Net Claim Code” to calculate the worker’s benefit rate Provide the amount or the code in each of the spaces provided.

(H2) Vacation pay – on each cheque?

Check (√) whether vacation pay is given on each pay cheque and provide the actual percentage.

Vacation pay issued on each cheque will be included in calculating the worker’s benefit

The information requested in questions 3 to 6 is used to determine when payment of loss of earnings to the worker is to start.

Please Note: The employer is responsible for full wages on the day of accident. WSIB benefit payments may begin after that day.

7. Advances on wages: Is the worker being paid while he/she recovers? ☐ yes ☐ no If yes, indi(H7) ☐ 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. (H8)

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			$	$	$	$	$	$

(H7) Advances on wages

Check (√) whether you are continuing to pay the worker all or part of his/her salary when the worker may be entitled to WSIB benefits.

Indicate "Full/Regular" when you continue the worker's full salary, or "Other" when you:

- continue a percentage of the worker's regular salary
- give a loan or lump sum advance
- have any other arrangement.

In cases where advances are being extended by the employer, we will redirect benefit entitlement to that employer at the rate we would normally pay the worker, if lost time is allowed

(H8) Other earnings (not regular wages)

Provide the total of additional earnings for each week for the 4 weeks before the accident/illness.

A worker may have additional earnings on top of his or her regular rate of pay (provided in section G – Question 2). These additional earnings could be:

- overtime pay (mandatory and/or voluntary)
- premiums
- commissions
- bonuses
- differentials
- tips & gratuities
- room & board
- in-lieu of payments, etc…

For a complete list of allowable earnings, see WSIB Policy #18-02-02, available on our website **wsib.ca** in the Policy tab under "Operational Policy Manual".

We may include these additional earnings, along with the regular rate of pay, when calculating a worker's benefit rate.

The "Other Earnings" chart is to help the employer provide us with any additional earnings information based on the four weeks prior to the accident/illness. Provide us the "From Date" and "To Date" for each week

There are six columns provided, two for overtime and four for other earnings. The untitled columns can be used to capture types of earnings, such as: premiums, bonuses, commissions, tips & gratuities, etc. Please provide the total weekly gross amount for each type of earning you indicate.

Mandatory Overtime:

Hours of work, in addition to regularly scheduled work hours that the worker cannot refuse

Voluntary Overtime:

Hours of work, in addition to regularly scheduled work hours, where the worker has the option of working the overtime.

Example: Dennis normally earns $12.58 per hour, is a Monday to Friday worker, 37.5 hours per week. However, prior to the date of accident/illness (02May2005), Dennis worked mandatory overtime of 6 hours per week for 2 of the 4 weeks ($18.87 per hour for the weeks of April 4th and 18th), and also received an evening premium of $1.25/hr for 20 hours (week of April 11th). The chart for this earnings situation would be completed as follows:

Rotational Shift Worker: An employee with a permanent shift schedule, with workdays that vary each week based on a specific rotation. A worker who is a rotational shift worker, may have a shift schedule in which the complete shift rotation may exceed the 4 weeks as provided for in the chart. If this is the case, provide (on a separate sheet as an attachment to the Form 7) the worker's complete earnings for the entire shift rotation prior to the accident/illness. The earnings provided should be broken down in the same manner as in the chart below

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

For additional information see Fact Sheet #1025A: “Reporting Earnings for Workers with Irregular Hours/Work Days”, available on our website wsib.ca in the Reference tab under “General”.

Period	From Date	To Date	Mandatory OT	Voluntary OT	Evening Premium
Week 1	25Apr2005	29Apr2005			
Week 2	18Apr2004	22Apr2005	$113.22		
Week 3	11Apr2005	15Apr2005			$25.00
Week 4	04Apr2005	08Apr2005	$113.22		

Section I – Work schedule

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

(A.) Regular Schedule - Indicate normal work days and hours. I1

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 I2

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). I3

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

I1 (A)Regular schedule – indicate normal work days and hours.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Provide the schedule the worker normally works if the worker has a regularly established work pattern.

Example:

The worker may work regularly Monday to Friday, 7.5 hours per day, 37.50 hours per week.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	7.5	7.5	7.5	7.5	7.5	

The worker may work weekends only, Friday to Sunday, 12 hours per day, 36 hours per week.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
2					2	2

The worker may work part-time, on the same days, week after week.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

I2 (B) Repeating rotational shift worker

Number Of Days On	Number Of Days Off	Hours Per Shift(s)	Number Of Weeks In Cycle

If this worker's shift rotation repeats according to a set schedule, please provide it here. If the rotation cannot be captured by this design, please provide the rotation pattern on a separate sheet as an attachment to the Form 7.

EXAMPLE:
The worker…

Number Of Days On	Number Of Days Off	Hours Per Shift(s)	Number Of Weeks In Cycle
4	4	12	8

The worker…

Number Of Days On	Number Of Days Off	Hours Per Shift(s)	Number Of Weeks In Cycle
21	7	8	4

I3 (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.)

This worker's schedule changes from day-to-day, week-to-week, etc. For the four week period prior to the accident/illness, provide us with the "From/To Dates", the "Total Hours Worked" and the "Total Shifts Worked" each week (do not include overtime here).

Example: Bruce is a casual/irregular worker (custodian) who only reports for work when called. For the date of accident of 02May2005, the chart may appear as follows:

	Week 1	Week 2	Week 3	Week 4

From/To Dates (dd/mm/yy)	24Apr2005 – 30Apr2005	17Apr2005 – 23Apr2005	10Apr2005 – 16Apr2005	03Apr2005 – 09Apr2005
Total Hours Worked	2	21		
Total Shifts Worked		4		

Charmaine is a permanent part time worker (retail store sales clerk) who works between 20-24 hours per week, but the days/hours worked per week always change. For the date of accident of 02May2005, the chart may appear as follows:

	Week 1	Week 2	Week 3	Week 4
From/To Dates (dd/mm/yy)	24Apr2005 – 30Apr2005	17Apr2005 – 23Apr2005	10Apr2005 – 16Apr2005	03Apr2005 – 09Apr2005
Total Hours Worked	24	20	21	20
Total Shifts Worked	3	4	4	

For further information, please refer to the Fact Sheet "Reporting Earnings for Worker's With Varied Work Patterns", available on our website wsib.ca in the Reference tab under "General."

Section J – Employer declaration

The person completing this report, on behalf of the employer, is to provide their name and contact information here. Their signature, as part of this declaration indicates that the information provided on each page is true. This person may be contacted to confirm or clarify information on the Form 7, as well as to obtain any missing or additional information

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

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