wsib ONTARIO

Employer's continuity report (REO7)

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REO7

Claim number

Claimant's name	Claim number	Date of injury/illness

Business name	Injury	Date of recurrence/re-injury

1. a) Describe what the claimant reports as the cause of this recurrence.

b) Date of reporting (dd/mmm/yyyy)

2. a) Did the claimant receive health care for this recurrence? ☐ Yes ☐ No

If yes, when? (dd/mmm/yyyy)

b) When did the business learn that the claimant received health care? (dd/mmm/yyyy)

c) Where was the claimant treated for this recurrence?

☐ On-site medical ☐ Emergency department ☐ Health care professional

☐ Clinic ☐ Other

Name/location of health professional/facility

3. Are you aware of any factors or other problems, aside from the original work injury, which may have contributed to this claimant's recurrence? ☐ Yes ☐ No

If **yes**, provide details here **or** ☐ Submission attached

4. From to , has the claimant been performing their regular work duties? ☐ Yes ☐ No

If **no**, describe the work duties performed

5. From to , has the claimant reported or discussed any ongoing problems with anyone at work about this condition? ☐ Yes ☐ No

If **yes**, names and positions

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

Ce document est disponible en français sous le titre : *Rapport de l'employeur (continuation d'invalidité) (REO7),* 2233B (05/23)

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6. From to , has the claimant sought any medical treatment for this condition? ☐ Yes ☐ No ☐ Unknown

If **yes**, from who?

☐ Chiropractor ☐ Physiotherapist ☐ Hospital ☐ Physician

☐ Registered nurse (extended class) ☐ Other (specify)

7. Between to , did the claimant miss any time from work due to this condition ☐ Yes ☐ No

If **yes,** provide dates.

8. Choose one of the following indicators. **As a result of this recurrence/re-injury, the claimant:**

☐ Returned to their **regular work** and **has not** lost any time and/or earnings.

☐ Returned to **modified work** and **has not** lost any time and/or earnings.

☐ **Has** lost time and/or earnings.

↳ Date claimant first lost time and/or earnings (dd/mmm/yyyy)

Date claimant returned to work (if known) (dd/mmm/yyyy)

☐ Regular work ☐ Modified work

9. The lost time/no lost time/modified work information was confirmed by: ☐ Myself ☐ Other

Name	Phone	Extension

It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I declare that all of the information provided is true.

Name of person completing this report	Official title	Phone	Extension

Signature	Date (dd/mmm/yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.