

Claim Number

Please PRINT in black ink

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
How long have you been doing this job for this employer?				Date of Birth	
Only check if you are one of the following: <input type="checkbox"/> executive <input type="checkbox"/> elected official <input type="checkbox"/> owner <input type="checkbox"/> spouse or relative of the employer				dd mm yy	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	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? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you authorize your union to represent you in this claim? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes , do you consent to the disclosure of verbal claim file status information to your union representative? <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																																																											
1. 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	2. Who did you report this accident/illness to? (Name & Position) _____ Telephone _____																																																										
3. 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></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"/> Other: _____			<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"/> Forearm	<input type="checkbox"/>			<input type="checkbox"/> Lower Leg	<input type="checkbox"/>			Are you: <input type="checkbox"/> Left Handed <input type="checkbox"/> Right handed	
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4. 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.):																																																										
5. Did it happen outside the Province of Ontario? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes , indicate where (city, province/state, country):																																																										
6. Have you hurt this area(s) of your body before? <input type="checkbox"/> yes <input type="checkbox"/> no	7. 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																																																										

A guide to complete this form is available at www.wsib.on.ca

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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"/> Ambulance	
<input type="checkbox"/> Emergency Department			<input type="checkbox"/> Health Professional Office	
<input type="checkbox"/> Admitted to Hospital			<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

2. If you lost time, have you returned to work? yes no

If yes ↳ Date of your return to work 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, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the WSIB's "Functional Abilities Form for Planning Early and Safe Return to Work".

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 *Workplace Safety and Insurance Act, 1997*. Your personal information will be used to administer your claim(s) and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, Canada Revenue Agency (CRA), 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, third parties for cost recovery purposes 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. Incoming and outgoing calls may be recorded for quality assurance purposes. Questions about this collection should be directed to the decision maker responsible for your file or by calling 1-800-387-0750.

A more detailed PRIVACY STATEMENT for workers may be found at www.wsib.on.ca or by calling toll free at 1-800-387-0750.

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K. Additional Information

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