

Mail To:
200 Front Street West
Toronto ON M5V 3J1

OR FaxTo:
416-344-4684
OR 1-888-313-7373

REO7

Employer's Continuity Report (Form REO7)

Claim Number	Desk No.	Alloc. No.
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Please PRINT in black ink

Worker's Name	Worker's Reference Number	Original Date of Accident/Injury
Accident Employer Name	Injury	Date of Recurrence/Re-injury

1. a) Describe what the worker reports as the cause of this recurrence.
b) Date of reporting
dd mm yy

2. a) Did the worker receive health care for this present recurrence? yes no If yes, when? dd mm yy b) When did the employer learn that the worker received health care? dd mm yy
c) Where was worker treated for this present recurrence?
 On-site medical Emergency department Health professional office 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 worker's present recurrence? yes no If yes, provide details here or Submission attached

4. From to , has this worker been performing his/her regular work duties? yes no
If no, describe the work duties performed

5. From to , has this worker reported or discussed any ongoing problems with anyone at work about this condition?
 yes no If yes, names and positions

6. From to , has this worker 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 this worker 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, this worker:
 Returned to his/her regular work and has not lost any time and/or earnings. (Complete only page 1)
 Returned to modified work and has not lost any time and/or earnings. (Complete only page 1)
 Has lost time and/or earnings. (Complete pages 1 and 2)
Date worker first lost time and/or earnings dd mm yy → Date worker returned to work (if known) dd mm yy regular work modified work

9. This Lost Time - No Lost Time - Modified Work information was confirmed by: Phone Ext.
 Myself Other (Name)

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 and 2 is true.

Name of person completing this report (please print)	Official title
Signature	Phone Ext. Date (dd/mm/yy)

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REO7E

Pre -1998 - Re-open Claim Earnings (Form REO7E)

**Report the worker's earnings
at the time of the recurrence.**

Claim Number
Date of Recurrence/Re-injury

Worker Name	Original Date of Accident/Injury (DOA)
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Section A Earnings - Complete if DOA is from April 1, 1985 to January 1, 1998

1. Regular rate of pay \$ _____ per hour day week other _____

2. Net Claim Code or Amount
Federal Provincial

3. Actual working hours on last day worked From <input type="checkbox"/> AM <input type="checkbox"/> PM To <input type="checkbox"/> AM <input type="checkbox"/> PM	4. Normal working hours for last day worked From <input type="checkbox"/> AM <input type="checkbox"/> PM To <input type="checkbox"/> AM <input type="checkbox"/> PM	5. Actual earnings on last day worked \$ _____	6. Normal earnings for last day worked \$ _____
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7. Other Earnings (Not Regular Wages)
Provide **any** additional earnings for this worker which is over and above his/her regular/base rate of pay (COLA, Differentials, Shift Premiums, Commissions, Tips, In Lieu of %, etc....)

Earnings Type (List Individually) *	Average Gross Weekly
	\$ _____
	\$ _____
	\$ _____

* If additional types, please attach.

8. Advances on Wages
Is the worker being paid while he/she recovers? yes no

If yes, indicate:
 Full/Regular Paid by Employer
 Other Third Party/Insurance Plan

If by a third party/insurance plan, provide name and telephone.
 Name _____ Phone _____

9. (A) Normal/Regular Working Days/Hours - Provide this worker's normal working days with "F" for full day and "H" for half-day and the total number of hours worked.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

Example

S	M	T	W	T	F	S	Total
	F	F	F	F	H		36

(B) For Repeating Rotational Shift Worker - Provide:

Average Shifts Worked per Week	Number of Hours per Shift
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Section B Earnings - Complete if DOA is before April 1, 1985

1. Actual working hours on last day worked From <input type="checkbox"/> AM <input type="checkbox"/> PM To <input type="checkbox"/> AM <input type="checkbox"/> PM	2. Normal working hours for last day worked From <input type="checkbox"/> AM <input type="checkbox"/> PM To <input type="checkbox"/> AM <input type="checkbox"/> PM	3. Actual earnings on last day worked \$ _____	4. Normal earnings for last day worked \$ _____
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5. Provide the **total gross earnings** for this worker for each of the 4 weeks immediately before layoff:

Period	From Date (dd/mm/yy)	To Date (dd/mm/yy)	Total Gross Earnings
Week 1			\$ _____
Week 2			\$ _____
Week 3			\$ _____
Week 4			\$ _____

6. Advances on Wages
Is the worker being paid while he/she recovers? yes no

If yes, indicate:
 Full/Regular Paid by Employer
 Other Third Party/Insurance Plan

If by a third party/insurance plan, provide name and telephone.
 Name _____ Phone _____

7. Normal/Regular Working Days/Hours - Provide this worker's normal working days with "F" for full day and "H" for half-day and the total number of hours worked.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

Example

S	M	T	W	T	F	S	Total
	F	F	F	F	H		36

Signature	Date (dd/mm/yy)
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