

| | | |
|--------------|----------|------------|
| Claim Number | Desk No. | Alloc. No. |
|--------------|----------|------------|

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:
 Myself Other (Name) Phone Ext.

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) |

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

Claim Number

| | | |
|-------------|--|------------------------------|
| Worker Name | Original Date of Accident/Injury (DOA) | Date of Recurrence/Re-injury |
|-------------|--|------------------------------|

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

| | |
|---|--|
| 2. Net Claim Code or Amount Federal <input style="width:100px;" type="text"/> Provincial <input style="width:100px;" type="text"/> | 3. Vacation pay on each cheque? <input type="checkbox"/> yes <input type="checkbox"/> no Provide percentage _____ % |
|---|--|

| | | | |
|---|--|---|--|
| 4. 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 | 5. 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 | 6. Actual earnings on last day worked \$ _____ | 7. Normal earnings for last day worked \$ _____ |
|---|--|---|--|

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

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

Paid by Employer Third Party/Insurance Plan

If by a third party/insurance plan, provide Name _____ Phone _____

9. **Other Earnings (Not Regular Wages):** Provide the **total of additional earnings** for each week for the 4 weeks before the recurrence/re-injury.

* 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 recurrence/re-injury

Use these spaces for any other earnings (indicate Differentials, Premiums, Tips, 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 | | | \$ | \$ | \$ | \$ | \$ | \$ |

Regular Production Bonuses/Commission

If paid weekly Did this worker receive payment in each of the 4 weeks before the layoff? yes no If yes, what is the average gross weekly amount? \$ _____

If paid monthly Did this worker receive payment in each of the 3 months before the layoff? yes no If yes, what is the average gross monthly amount? \$ _____

Is worker receiving any payments in lieu of benefits? yes no If yes, what is the % _____

10. **Work schedule** (complete either A or B or C, **do not** include overtime shifts.)

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

| | | | | | | |
|--------|--------|---------|-----------|----------|--------|----------|
| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
| | | | | | | |

Example

| | | | | | | |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
| | 8 | 8 | 8 | 8 | 8 | |

(B) **Repeating Rotational Shift Worker** - Provide:

| | | | |
|-------------------|--------------------|--------------------|--------------------------|
| 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

(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 recurrence/re-injury. (Do not include overtime hours or shifts here).

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

| | |
|-----------|-----------------|
| Signature | Date (dd/mm/yy) |
|-----------|-----------------|