

Claim Number

Please PRINT in black ink

Worker's Name	Original Date of Accident/Injury	Injury
Accident Employer Name	If any information is incorrect, please provide the changes here:	

1. Please check which status best describes your current condition

Recovered     Getting Better  
 No Change     Getting Worse

Describe any details or changes to your condition

2. Who is the primary health professional directing your current treatment?

Name \_\_\_\_\_ Date of last visit \_\_\_\_\_ (dd mm yy) Date of next visit \_\_\_\_\_ (dd mm yy)

3. Please specify any referrals you have not yet reported to the WSIB

no new referrals     testing (e.g. labs, x-rays, CT Scan, MRI, etc.)     specialist     other (specify) \_\_\_\_\_

Name/Facility \_\_\_\_\_ Date of that appointment \_\_\_\_\_ (dd mm yy)

4. Are you presently taking any drugs/medications or using an assistive device/brace for this injury?  yes  no

If **yes**, list names \_\_\_\_\_

5. Have you worked for any employer(s) or were you self employed between the first day off and now?  yes  no

If **yes**, provide details including dates, name/address of employer/company \_\_\_\_\_

6. Choose **one** of the following that best describes your **current** situation. **For this claim,**

I **have not** lost any time or pay from work (complete **only** question 7)  
 I **have** lost time and/or pay and **have** returned to work (complete **only** questions 7 and 8)  
 I **have** lost time and **have not** returned to work (complete **only** questions 9 to 12)

7. Was your return to work to	a) <input type="checkbox"/> regular work <b>OR</b> <input type="checkbox"/> modified work b) <input type="checkbox"/> regular pay <b>OR</b> <input type="checkbox"/> lower pay c) <input type="checkbox"/> regular hours <b>OR</b> <input type="checkbox"/> less hours	8. Date of your return to work _____ (dd mm yy)
9. Have you talked to your health professional about return to work? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , date of last discussion _____	10. Have you talked to your employer about return to work? <input type="checkbox"/> yes <input type="checkbox"/> no
and have they determined your work limitations or functional abilities? <input type="checkbox"/> yes <input type="checkbox"/> no		If <b>yes</b> , date of last discussion _____ name of person you talked to _____
11. Has any type of work been offered to you? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , provide details _____	
12. Are there any other factors that are preventing you from returning to work? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , provide details _____	

**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 this page is true.**

Signature	Date dd/mm/yy
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