

Claim No.	Desk No.	Alloc. No.
Injury		
Date	Date of Injury	
Employer's Name and Address		
To Enquire, Contact () For toll free number, check local directory.		

Ce formulaire est disponible en français sur demande.

Please print Name and Address above.

Your Preferred Language of Service	
<input type="checkbox"/> English	<input type="checkbox"/> French
Other language if you speak neither English/French	

A. Personal Information

Social Insurance Number	Sex	Date of Birth day month year	Other language if you speak neither English/French
-------------------------	-----	---------------------------------	----------------------------------------------------

B. Employment Information

Job at time of injury	Date of Hire day month year	Date started on job day month year
-----------------------	--------------------------------	---------------------------------------

C. Accident Details

Date of Injury day month year	Date Reported day month year	Reported to: Name:	Position:
Lost time from work: <input type="checkbox"/> No <input type="checkbox"/> Yes	From: day month year	To: day month year	Still off work <input type="checkbox"/> Yes
Daily/Hourly Rate	Working Days s m t w th f s	Hours per week	

What part/s of your body was/were injured?

IF YOU CAN IDENTIFY A SPECIFIC INCIDENT THAT CAUSED YOUR INJURY, ANSWER THE FOLLOWING QUESTIONS. IF YOUR CONDITION CAME ON GRADUALLY OVER TIME, PLEASE ANSWER QUESTIONS ON THE FOLLOWING PAGE.

Describe what happened to cause your injury (ie. lifted box, slipped on wet floor). Please indicate the size and weight of any objects involved.

Name any witnesses or co-workers aware of your injury:

If you delayed in reporting your accident, explain why:

IF YOUR CONDITION CAME ON GRADUALLY OVER TIME, ANSWER THE FOLLOWING QUESTIONS.

1. Describe the work you do and what you believe caused your condition. Include the size and weight of any objects you use. How many times per hour/day do you go through the same motion?

2. When did you first notice the pain? Were there any changes to your job at that time such as increased production rate, longer work hours or equipment/line changes?

3. Did you mention your pain to any supervisors or co-workers? Please provide the names, positions, and approximate dates and frequency of complaints.

4. Are you left or right handed? <input type="checkbox"/> Left <input type="checkbox"/> Right	5. When did you first go to First Aid or a doctor? day month year
--------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------

D. General Information

Name of Doctor:	Telephone No. ()
-----------------	----------------------

Address	Province	Postal Code
---------	----------	-------------

Date seen: day month year 	PLEASE LET YOUR DOCTOR(S) KNOW YOUR WSIB CLAIM NO.
-------------------------------	-----------------------------------------------------------

Prior similar injury/condition? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, any previous claims? <input type="checkbox"/> WSIB <input type="checkbox"/> Other (explain)
---------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------

Are you a member of a union?
 No Yes

If yes, do you authorize the union to represent you in matters before the Workplace Safety and Insurance Board?
 No Yes

If yes, give the name and telephone number of the union representative.

By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I consent to the collection of all information relating to this claim by the Board. 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 Board's "Functional Abilities Form for Timely Return to Work".			
Signature	Date	Telephone No. ()	
If you are under the age of 16, your parent, or guardian, must authorize the release of the functional abilities information.			
Signature	Relationship	Date	Telephone No. ()

The Workplace Safety and Insurance Act, 1997, requires you to give a copy of this form to your employer.

Personal information relating to you will be collected throughout your claim under the authority of the Workplace Safety and Insurance Act, 1997, S.O. 1997, c.16, Schedule A., and will be used to administer your claim and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses and others as required. Information may be disclosed to the employer, external medical, vocational, safety agencies, external service and payment providers, researchers 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. Questions about the collection should be directed to the decision maker responsible for your file.