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wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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

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

REO6

Worker's Continuity Report (Form REO6)

start > Claim Number

Please PRINT in black ink

Worker's Name	Are you still with the same employer as when you were originally injured? ☐ yes ☐ no If **no**, provide your new employer name and address
Original Date of Accident/Injury / Date of Recurrence/Re-Injury	
Injury	May we contact your new employer? ☐ yes ☐ no Telephone

1. a) Do you feel your present problems are the result of your original work injury? ☐ yes ☐ no

b) From to , describe why it is worse along with any details or changes to your condition.

2. From to , have you had any medical treatment for your work injury? ☐ yes ☐ no

If **yes**, who did you see and how often?

3. From to , list the names of any drugs/medications or assistive devices/braces you have been using for ongoing problems related to your work injury.

4. From to , have there been any changes to the **work** that you have been doing? ☐ yes ☐ no

If **yes**, describe the changes.

5. From to , have you reported or discussed any ongoing problems with anyone at work? ☐ yes ☐ no

If **yes**, names and positions.

6. From to , did you miss any time from work due to your work injury? ☐ yes ☐ no

If **yes**, what are those dates?

7. Choose **one** of the following: **Due to this present recurrence:**

☐ I have returned to **regular work** and **have not** lost time and/or pay. (complete **only** question **8**)
☐ I have returned to **modified work** and **have not** lost time and/or pay. (complete **only** questions **8 and 9**)
☐ I **have** lost time and/or pay → Date you first lost time and/or pay for this present recurrence dd mm yy (complete **only** questions **10 to 12**)

8. Was your return to work to
a) ☐ regular work **OR** ☐ modified work
b) ☐ regular pay **OR** ☐ lower pay
c) ☐ regular hours **OR** ☐ less hours

9. Date of your return to work dd mm yy

10. Have you talked to your health professional about return to work? ☐ yes ☐ no
If **yes**, date of last discussion dd mm yy
and have they determined your work limitations or functional abilities? ☐ yes ☐ no

11. Have you talked to your employer about return to work? ☐ yes ☐ no
If **yes**, date of last discussion dd mm yy
name of person you talked to

12. Is there an anticipated return to work date? ☐ yes ☐ no
If **yes**, what is the return to work date dd mm yy

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.

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."

Signature **Type your name and upload, or print and sign before returning to WSIB.** Date (dd/mm/yy)

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