

A. Worker information					
Last name		First name		Social Insurance Number	
Address (number, street, apt., suite, unit)				Telephone	
City/Town		Province	Postal code	Alternate/Cell phone	
Job title/Occupation (at the time you were hurt)		Date you started with employer (dd/mm/yy)		How long have you been doing this job for this employer?	
Only check if you are one of the following: executive elected official owner spouse or relative of the employer				Date of birth (dd/mm/yy)	
Sex Male Female		Your preferred language English French Other		Would an interpreter be helpful? yes no	
Are you a member of a union? yes no		Do you authorize your union to represent you in this claim? yes no		If yes, do you consent to the disclosure of verbal claim file status information to your union representative? yes no	
Provide your union name and local					

B. Employer information		
Company/Employer name		
Address		
City/Town		Province
Your immediate supervisor's name		Postal code
		Company telephone

C. Accident/illness dates and details																																																										
1. Date and hour of accident/Awareness of illness (dd/mm/yy) _____ AM PM		2. Who did you report this accident/illness to? (name and position) Telephone																																																								
Date and hour reported to employer (dd/mm/yy) _____ AM PM																																																										
3. Area of injury (body part) - (please check all that apply)																																																										
<table border="0"> <tr> <td>Head</td> <td>Teeth</td> <td>Upper back</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> </tr> <tr> <td>Face</td> <td>Neck</td> <td>Lower back</td> <td>Shoulder</td> <td></td> <td>Wrist</td> <td></td> <td>Hip</td> <td></td> <td>Ankle</td> <td></td> </tr> <tr> <td>Eye(s)</td> <td>Chest</td> <td>Abdomen</td> <td>Arm</td> <td></td> <td>Hand</td> <td></td> <td>Thigh</td> <td></td> <td>Foot</td> <td></td> </tr> <tr> <td>Ear(s)</td> <td></td> <td>Pelvis</td> <td>Elbow</td> <td></td> <td>Finger(s)</td> <td></td> <td>Knee</td> <td></td> <td>Toe(s)</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Forearm</td> <td></td> <td></td> <td></td> <td>Lower leg</td> <td></td> <td></td> <td></td> </tr> </table>	Head	Teeth	Upper back	Left	Right	Left	Right	Left	Right	Left	Right	Face	Neck	Lower back	Shoulder		Wrist		Hip		Ankle		Eye(s)	Chest	Abdomen	Arm		Hand		Thigh		Foot		Ear(s)		Pelvis	Elbow		Finger(s)		Knee		Toe(s)					Forearm				Lower leg				Other:		Are you: Left handed Right handed
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4. Did the accident/illness happen on the employer's property or work site?		yes no	Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):																																																							
5. Did it happen outside the Province of Ontario?		yes no	If yes, indicate where (city, province/state, country):																																																							
6. Have you hurt this area(s) of your body before?		yes no	7. Do you have any prior related WSIB/WCB claims? no yes - in Ontario yes - outside Ontario																																																							

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

Upload forms and supporting documents online at wsib.ca/upload

Mail: 200 Front Street West, Toronto, Ontario, M5V 3J1 | **Toll free:** 1-800-387-0750 | **TTY:** 1-800-387-0050 | **Fax:** 1-888-313-7373
0006A (11/20)

Claim number

Last name	First name	Social Insurance Number
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C. Accident/illness dates and details (continued)

8. If you had a sudden type of accident/illness, describe your injury and what happened to cause it (e.g. hurt lower back while lifting a 50 pound box, sprained left ankle when I slipped on a wet floor, used a new cleaner and immediately got a rash). Please indicate the size, weights and names of any objects involved.
or
 If you had a gradual onset type of injury, describe your injury, the work that you do and what you believe caused your injury/condition.

9. When did you first start to have problems with this injury/condition?

10. If you did not report this to your employer right away, please tell us the reason why.

11. If there were any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, give us their names and positions.

	Name	Position
1		
2		

12. The Workplace Safety and Insurance Act requires your employer to give you a copy of the Employer's Report of Injury/Disease (Form 7).
 Did you receive a copy of the Form 7? yes no
The Workplace Safety and Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer

D. Health care information - Give your health professional your WSIB claim number

1. Did you get first aid or care at work? yes no If yes, when (dd/mm/yy) and by whom (name):

2. Where did you go for health care, for your injury, outside of work? (check all that apply)

	Facility/Hospital (name and address)		Date of visit (dd/mm/yy)
Nursing Station		Ambulance	
Emergency Department		Health professional office	
Admitted to hospital		Clinic	
	Date of visit (dd/mm/yy)		

3. Were you prescribed any medications/drugs? yes no 4. Were you referred for any other treatment or tests? yes no

5. Did you talk to your health professional about going back to regular or modified work? yes no If yes, were you given any work limitations? yes no

6. Did you tell your employer you went for medical treatment? yes no **If no, please tell your employer right away.**
 If yes, when? (dd/mm/yy) and to whom (name and position):

Claim number

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E. Lost time and return to work

1. After the day of accident/illness:

I returned to work to my **regular job** and **did not** lose any time or pay.

I returned to **modified duties** and **did not** lose any time or pay.

I lost time and/or pay (e.g. regular pay, shift differential, bonuses, premiums, etc.).

Date you first lost time and/or pay (dd/mm/yy)

2. If you lost time, have you returned to work? yes no

If **yes**, date of your return to work (dd/mm/yy)

Regular work

Modified work

If **no**, did you discuss return to work with your employer? yes no

Does your employer have modified work? yes no

F. Earnings (do not include overtime here)

1. Rate of pay

\$ per hour week other

2. Usual number of pay hours

..... per week other

3. If you lost time from work after the day of accident/illness, did your employer continue to pay you? yes no

4. Have you applied for, or did you receive, any other benefits (money) while off work (e.g. EI benefits, sick benefits, social services, insurance, etc.)? yes no

5. At the time of the accident/illness did you work for more than one employer? yes no

G. Declarations and signature

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".

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, 2 and 3 is true.

Signature (print, sign and return to the WSIB or type and upload)	Date (dd/mm/yy)
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If you are under the age of 16, your parent or guardian, must authorize the release of the functional abilities information.

Signature	Relationship	Date (dd/mm/yy)	Telephone
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Personal information about you will be collected throughout your claim under the authority of the *Workplace Safety and Insurance Act*, 1997. Your personal information will be used to administer your claim(s) and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, Canada Revenue Agency (CRA), and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax statements and is collected under the authority of the *Income Tax Act*. Information may only be disclosed to the employer, external medical consultants, external service providers, researchers, third parties for cost recovery purposes 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 parties conducting satisfaction surveys and focus groups. Incoming and outgoing calls may be recorded for quality assurance purposes. Questions about this collection should be directed to the decision maker responsible for your file or by calling 1-800-387-0750

You can find a more detailed privacy statement at wsib.ca or by calling toll-free at 1-800-387-0750.

 Upload form and supporting documents online at wsib.ca/upload.

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H. Additional information