WSIB Form

The information on this form is used in determining a patient's entitlement to compensation, therefore, please complete fully.

Name: ____ Date: ________________________

SIN: ________________________________ Date of Accident (DD/MM/YY): _________________________

Claim Number (if known): ____

Employer's Name: ____

Employer Phone Number: __________________________________ Fax Number: ______________________

Supervisor: ____ Phone Number: _____________________

Employer's Address: ____

____

Current Job Title/Occupation: ____

Length of time in current job: ______ years _______ months

Employment status at the time of injury:

- ☐ Full time
- ☐ Part Time
- ☐ Regular Hours
- ☐ Modified Hours
- ☐ Regular Work
- ☐ Modified Work
- ☐ Not Working

If not working, how long do you think you will be off work?: ____

Has this accident been reported to your employer? □ Yes □ No

Have you had a previous similar disability? ____________ If so when? _________________________________

Have you seen other doctors for this injury? If so, whom, when and what was the outcome? _________________

____

How did the injury/re-injury occur at work? ____

____

When did you first notice the pain? ____

Where do/did you feel the pain? ____

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