WSIB ONTARIO CSPAAT

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

OR Fax To:
416-344-4684
OR 1-888-313-7373

Please PRINT in black ink

7 Employer's Report of Injury/Disease (Form 7)

Claim Number

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations)	Length of time in this position while working for you	Social Insurance Number
Please check **if** this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer		

start

Last Name | First Name

Address (number, street, apt., suite, unit)

City/Town | Province | Postal Code

Is the worker covered by a Union/Collective Agreement? ☐ yes ☐ no	Worker Reference Number
Worker's preferred language ☐ English ☐ French ☐ Other	Date of Birth dd mm yy
	Telephone
Sex ☐ M ☐ F	Date of Hire dd mm yy

B. Employer Information

Fold here for #10 envelope

Trade and Legal Name (if different provide both)		Check one: ☐ Firm Number **OR** ☐ Account Number	Provide Number
Mailing Address		Rate Group Number	Classification Unit Code
City/Town	Province	Postal Code	Telephone
Description of Business Activity	Does your firm have 20 or more workers? ☐ yes ☐ no		FAX Number
Branch Address where worker is based (if different from mailing address - no abbreviations)			
City/Town	Province	Postal Code	Alternate Telephone

C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness dd mm yy ☐ AM ☐ PM

Date and hour reported to employer dd mm yy ☐ AM ☐ PM

2. Who was the accident/illness reported to? (Name & Position)

Telephone | Ext.

3. Was the accident/illness:
- ☐ Sudden Specific Event/Occurrence
- ☐ Gradually Occurring Over Time
- ☐ Occupational Disease
- ☐ Fatality

4. Type of accident/illness: **(Please check all that apply)**
- ☐ Struck/Caught
- ☐ Overexertion
- ☐ Repetition
- ☐ Fire/Explosion
- ☐ Fall
- ☐ Harmful Substances/Environmental
- ☐ Assault
- ☐ Other
- ☐ Slip/Trip
- ☐ Motor Vehicle Incident

5. Area of Injury (Body Part) - **(Please check all that apply)**

- ☐ Head
- ☐ Face
- ☐ Eye(s)
- ☐ Ear(s)
- ☐ Teeth
- ☐ Neck
- ☐ Chest
- ☐ Upper back
- ☐ Lower back
- ☐ Abdomen
- ☐ Pelvis
- ☐ Other

Left		Right
☐	Shoulder	☐
☐	Arm	☐
☐	Elbow	☐
☐	Forearm	☐

Left		Right
☐	Wrist	☐
☐	Hand	☐
☐	Finger(s)	☐

Left		Right
☐	Hip	☐
☐	Thigh	☐
☐	Knee	☐
☐	Lower Leg	☐

Left		Right
☐	Ankle	☐
☐	Foot	☐
☐	Toe(s)	☐

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc. . .). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

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Worker Name	Social Insurance Number

C. Accident/Illness Dates and Details (Continued)

start

7. Did the accident/illness happen on the employer's premises (owned, leased or maintained)? ☐ yes ☐ no — Specify where (shop floor, warehouse, client/customer site, parking lot, etc..).

8. Did the accident/illness happen outside the Province of Ontario? ☐ yes ☐ no — If **yes,** where (city, province/state, country).

9. Are you aware of any witnesses or other employees involved in this accident/illness? ☐ yes ☐ no — If **yes,** provide name(s), position(s), and work phone number(s).

1. .....

2. .....

10. Was any individual, who does not work for your firm, partially or totally responsible for this accident/illness? ☐ yes ☐ no — If **yes,** please provide name and work phone number .....

11. Are you aware of any prior similar or related problem, injury or condition? ☐ yes ☐ no — If **yes,** please explain

12. If you have concerns about this claim, attach a written submission to this form. ☐ submission attached

D. Health Care

1. Did the worker receive health care for this injury? ☐ yes ☐ no — If **yes,** when : dd mm yy

2. When did the employer learn that the worker received health care? dd mm yy

3. Where was the worker treated for this injury? **(Please check all that apply)**

☐ On-site health care ☐ Ambulance ☐ Emergency department ☐ Admitted to hospital ☐ Health professional office ☐ Clinic

☐ Other: .....

Name, address and phone number of health professional or facility who treated this worker (if known) .....

.....

.....

E. Lost Time - No Lost Time

1. Please choose one of the following indicators. **After the day of accident/awareness of illness, this worker:**

☐ Returned to his/her **regular job** and **has not** lost any time and/or earnings. **(Complete sections G and J).**

☐ Returned to **modified work** and **has not** lost any time and/or earnings. **(Complete sections F, G, and J).**

☐ **Has** lost time and/or earnings. **(Complete ALL remaining sections).**

▶ Provide date worker first lost time dd mm yy

▶ Date worker returned to work (if known) dd mm yy ☐ regular work ☐ modified work

2. This Lost Time - No Lost Time - Modified Work information was confirmed by: Telephone Ext.

☐ Myself ☐ Other

Name .....

F. Return To Work

1. Have you been provided with work limitations for this worker's injury? ☐ yes ☐ no

2. Has modified work been discussed with this worker? ☐ yes ☐ no

3. Has modified work been offered to this worker? ☐ yes ☐ no — If **yes,** was it ☐ Accepted ☐ Declined

☐ If Declined please attach a copy of the written offer given to the worker.

4. Who is responsible for arranging worker's return to work Telephone Ext.

☐ Myself ☐ Other

Name .....

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G. Base Wage/Employment Information - (Do not include overtime here)

Start

1. Is this worker **(Please check all that apply)**

- ☐ Permanent Full Time
- ☐ Permanent Part Time
- ☐ Temporary Full Time
- ☐ Temporary Part Time
- ☐ Casual/Irregular
- ☐ Seasonal
- ☐ Contract
- ☐ Student
- ☐ Unpaid/Trainee
- ☐ Other
- ☐ Registered Apprentice
- ☐ Optional Insurance
- ☐ Owner Operator or (Sub) Contractor

2. Regular rate of pay $ _____ per ☐ hour ☐ day ☐ week ☐ other _____

H. Additional Wage Information

1. Net Claim Code or Amount — Federal _____ Provincial _____

2. Vacation pay - on each cheque? ☐ yes ☐ no — Provide percentage _____ %

3. Date and hour last worked — dd mm yy ☐ AM ☐ PM

4. Normal working hours on last day worked — From ☐ AM ☐ PM To ☐ AM ☐ PM

5. Actual earnings for last day worked $ _____

6. Normal earnings for last day worked $ _____

7. Advances on wages: Is the worker being paid while he/she recovers? ☐ yes ☐ no If yes, indicate: ☐ Full/Regular ☐ Other _____

8. Other Earnings (Not Regular Wages): Provide the **total of additional earnings** for each week for the 4 weeks before the accident/illness.

* For Rotational Shift workers - If the shift cycle exceeds 4 weeks, please attach the earnings information for the last complete shift cycle prior to the date of accident/illness.

▼ Use these spaces for any other earnings (indicate Commission, Differentials, Premiums, Bonus, Tips, In Lieu %, etc..).

Period	From Date (dd/mm/yy)	To Date (dd/mm/yy)	Mandatory Overtime Pay	Voluntary Overtime Pay	Commission	Commission	Commission	Commission
Week 1			$	$	$	$	$	$
Week 2			$	$	$	$	$	$
Week 3			$	$	$	$	$	$
Week 4			$	$	$	$	$	$

I. Work Schedule (Complete either **A, B or C. Do not** include overtime shifts)

☐ **(A.) Regular Schedule** - Indicate normal work days and hours.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

▶ **Example:** Monday to Friday, 40 hours

S	M	T	W	T	F	S
	8	8	8	8	8	

or,

☐ **(B.) Repeating Rotational Shift Worker** - Provide

NUMBER OF DAYS ON	NUMBER OF DAYS OFF	HOURS PER SHIFT(s)	NUMBER OF WEEKS IN CYCLE

▶ **Example:** 4 days on, 4 days off, 12 hours per shift, 8 weeks in cycle.

or,

☐ **(C.) Varied or Irregular Work Schedule** - Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the accident/illness. (Do not include overtime hours or shifts here).

	Week 1	Week 2	Week 3	Week 4
From/To Dates (dd/mm/yy)	/	/	/	/
Total Hours Worked				
Total Shifts Worked				

J. 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.

Name of person completing this report (please print)	Official title	
Signature	Telephone Ext.	Date dd mm yy

Please print form & sign before returning to the WSIB

THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER

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Worker Name	Social Insurance Number

K. Additional Information

start

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