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

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

42 Employer's Progress Report (Form 42)

Claim Number	Desk No.	Alloc. No.

Please PRINT in black ink

Worker's Name	Worker Reference Number	Injury	Original Date of Accident/Injury

1. Choose **one** of the following which best describes the worker's current situation and complete remainder of form as indicated.

- ☐ This worker **has not** lost time or pay from work (complete **only** questions **2 and 3**)
- ☐ This worker **has** lost time and **has** returned to work (complete **only** questions **2 to 5**)
- ☐ This worker **has** lost time and **has not** returned to work (complete **only** questions **6 to 10**)

2. The worker returned to (check all that apply)

a) ☐ regular work **OR** ☐ modified work
b) ☐ regular pay **OR** ☐ reduction in pay
c) ☐ regular hours **OR** ☐ reduction in hours

Provide any explanation/details on this worker's return to work.

3. a) Indicate the return to work status

Return to work plan in place? ☐ yes ☐ no
Plan on schedule? ☐ yes ☐ no

b) Do you want WSIB assistance with this return to work? ☐ yes ☐ no

4. Date and time of return to work dd mm yy ☐ AM ☐ PM

5. a) Total number of shifts/days lost

b) If worker is repeating rotational shift work provide the length of each shift/day lost (e.g. 4 days on, 4 days off - OR - works a set schedule 5 days per week but days worked each week vary)

6. Who is responsible for arranging this worker's return to work?

☐ myself ☐ other name position phone ext.

7. Has contact been made with this worker to discuss his/her status and return to work? ☐ yes ☐ no Explanation/Details

If **yes**, date of last contact/discussion dd mm yy

What was the outcome of that discussion?

8. Have you received this worker's work limitations or functional abilities for a return to work? ☐ yes ☐ no

If **yes**, when did you receive them? dd mm yy

How did you receive them?
☐ WSIB Functional Abilities Form ☐ medical note
☐ your own Functional Abilities Form ☐ other

9. Are you able to accommodate this worker? ☐ yes ☐ no

10. Please outline why the worker has not returned 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 this page is true.

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