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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