WSIB ONTARIO CSPAAT

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

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

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

Claim Number

## A. Worker Information

Employer's Report Number:

| 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 | | |

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

Date and hour reported to employer dd mm yy

**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.**

WSIB ONTARIO CSPAAT

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

Claim Number

**Please PRINT in black ink**

| Worker Name | Social Insurance Number |
|---|---|
| | |

## C. Accident/Illness Dates and Details (Continued)

**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:

☐ Myself ☐ Other — Name — Telephone — Ext.

## 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

☐ Myself ☐ Other — Name — Telephone — Ext.

WSIB ONTARIO CSPAAT

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

Claim Number

**Please PRINT in black ink**

| Worker Name | Social Insurance Number |
|---|---|
| | |

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

**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 .....

**4.** Normal working hours on last day worked From ..... To .....

**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 | | | | |
|---|---|---|---|---|---|---|---|---|
| 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 |
| | | | |

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

WSIB ONTARIO CSPAAT

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

Claim Number

**Please PRINT in black ink**

| Worker Name | Social Insurance Number |
|---|---|
| | |

## K. Additional Information

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