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**Please note: Submitting a No Lost Time claim?  
Only complete sections A to D, E (#1) and J.**

Claim Number

Please PRINT in black ink

**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 <b>if</b> this worker is a: <input type="checkbox"/> executive <input type="checkbox"/> elected official <input type="checkbox"/> owner <input type="checkbox"/> spouse or relative of the employer				
Last Name _____ First Name _____		Is the worker covered by a Union/Collective Agreement? <input type="checkbox"/> yes <input type="checkbox"/> no		Worker Reference Number
Address (number, street, apt., suite, unit)		Worker's preferred language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other		Date of Birth dd mm yy
City/Town	Province	Postal Code	Telephone	
Sex <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Firm Number <b>OR</b> <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> 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 <input type="checkbox"/> AM <input type="checkbox"/> PM	2. Who was the accident/illness reported to? (Name & Position)
Date and hour reported to employer dd mm yy <input type="checkbox"/> AM <input type="checkbox"/> PM	Telephone _____ Ext. _____

3. Was the accident/illness: <input type="checkbox"/> Sudden Specific Event/Occurrence <input type="checkbox"/> Gradually Occurring Over Time <input type="checkbox"/> Occupational Disease <input type="checkbox"/> Fatality	4. Type of accident/illness: <b>(Please check all that apply)</b> <input type="checkbox"/> Struck/Caught <input type="checkbox"/> Fall <input type="checkbox"/> Slip/Trip <input type="checkbox"/> Overexertion <input type="checkbox"/> Harmful Substances/Environmental <input type="checkbox"/> Motor Vehicle Incident <input type="checkbox"/> Repetition <input type="checkbox"/> Assault <input type="checkbox"/> Fire/Explosion <input type="checkbox"/> Other
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5. Area of Injury (Body Part) - **(Please check all that apply)**

<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Upper back	Left	Right	Left	Right	Left	Right	Left	Right
<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Lower back	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/> Ankle	<input type="checkbox"/>
<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/> Thigh	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>
<input type="checkbox"/> Ear(s)		<input type="checkbox"/> Pelvis	<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/> Finger(s)	<input type="checkbox"/>	<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/> Toe(s)	<input type="checkbox"/>
<input type="checkbox"/> Other			<input type="checkbox"/> Forearm	<input type="checkbox"/>			<input type="checkbox"/> Lower Leg	<input type="checkbox"/>		

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.**

Please PRINT in black ink

Worker Name	Social Insurance Number
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<b>C. Accident/Illness Dates and Details (Continued)</b>	
<b>7.</b> Did the accident/illness happen on the employer's premises (owned, leased or maintained)? <input type="checkbox"/> yes <input type="checkbox"/> no	Specify where (shop floor, warehouse, client/customer site, parking lot, etc..).
<b>8.</b> Did the accident/illness happen outside the Province of Ontario? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , where (city, province/state, country).
<b>9.</b> Are you aware of any witnesses or other employees involved in this accident/illness? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , provide name(s), position(s), and work phone number(s). 1. _____ 2. _____
<b>10.</b> Was any individual, who does not work for your firm, partially or totally responsible for this accident/illness? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , please provide name and work phone number _____
<b>11.</b> Are you aware of any prior similar or related problem, injury or condition? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , please explain _____
<b>12.</b> If you have concerns about this claim, attach a written submission to this form. <input type="checkbox"/> submission attached	

<b>D. Health Care</b>	
<b>1.</b> Did the worker receive health care for this injury? <input type="checkbox"/> yes <input type="checkbox"/> no If <b>yes</b> , when : dd mm yy	<b>2.</b> When did the employer learn that the worker received health care? dd mm yy
<b>3.</b> Where was the worker treated for this injury? <b>(Please check all that apply)</b> <input type="checkbox"/> On-site health care <input type="checkbox"/> Ambulance <input type="checkbox"/> Emergency department <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Health professional office <input type="checkbox"/> Clinic <input type="checkbox"/> Other: _____ Name, address and phone number of health professional or facility who treated this worker (if known) _____ _____ _____	

<b>E. Lost Time - No Lost Time</b>	
<b>1.</b> Please choose one of the following indicators. <b>After the day of accident/awareness of illness, this worker:</b> <input type="checkbox"/> Returned to his/her <b>regular job</b> and <b>has not</b> lost any time and/or earnings. <b>(Complete sections G and J).</b> <input type="checkbox"/> Returned to <b>modified work</b> and <b>has not</b> lost any time and/or earnings. <b>(Complete sections F, G, and J).</b> <input type="checkbox"/> <b>Has</b> lost time and/or earnings. <b>(Complete ALL remaining sections).</b>	
Provide date worker first lost time dd mm yy	Date worker returned to work (if known) dd mm yy <input type="checkbox"/> regular work <input type="checkbox"/> modified work
<b>2.</b> This Lost Time - No Lost Time - Modified Work information was confirmed by: <input type="checkbox"/> Myself <input type="checkbox"/> Other Name _____ Telephone _____ Ext. _____	

<b>F. Return To Work</b>			
<b>1.</b> Have you been provided with work limitations for this worker's injury? <input type="checkbox"/> yes <input type="checkbox"/> no	<b>2.</b> Has modified work been discussed with this worker? <input type="checkbox"/> yes <input type="checkbox"/> no	<b>3.</b> Has modified work been offered to this worker? <input type="checkbox"/> yes <input type="checkbox"/> no	If <b>yes</b> , was it <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <input type="checkbox"/> If Declined please attach a copy of the written offer given to the worker.
<b>4.</b> Who is responsible for arranging worker's return to work <input type="checkbox"/> Myself <input type="checkbox"/> Other Name _____ Telephone _____ Ext. _____			

Please PRINT in black ink

Worker Name	Social Insurance Number
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**G. Base Wage/Employment Information** - (Do not include overtime here)

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

<input type="checkbox"/> Permanent Full Time	<input type="checkbox"/> Casual/Irregular	<input type="checkbox"/> Student	<input type="checkbox"/> Registered Apprentice	<input type="checkbox"/> Owner Operator or (Sub) Contractor
<input type="checkbox"/> Permanent Part Time	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Unpaid/Trainee	<input type="checkbox"/> Optional Insurance	
<input type="checkbox"/> Temporary Full Time	<input type="checkbox"/> Contract	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Temporary Part Time				

**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 \_\_\_\_\_ 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				
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. **Example:** Monday to Friday, 40 hours

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

**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

