wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail To:
Workplace Safety and Insurance Board
200 Front Street West
Toronto ON M5V 3J1

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

6 Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in black ink

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A. Worker Information

start ▸

Last Name	First Name	Social Insurance Number

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

City/Town | Province | Postal Code | Alternate/Cell Phone

Job Title/Occupation (at the time you were hurt) | Date you started with employer dd mm yy | How long have you been doing this job for this employer?

Only check **if** you are one of the following: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer | Date of Birth dd mm yy

Sex ☐ M ☐ F | Your Preferred Language ☐ English ☐ French ☐ Other | Would an interpreter be helpful? ☐ yes ☐ no

Are you a member of a union? ☐ yes ☐ no | Do you authorize your union to represent you in this claim? ☐ yes ☐ no | If **yes**, do you consent to the disclosure of verbal claim file status information to your union representative? ☐ yes ☐ no

Provide your Union Name and Local

B. Employer Information

Company/Employer Name

Address

City/Town | Province | Postal Code

Your Immediate Supervisor's Name | Company Telephone

C. Accident/Illness Dates & 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 did you report this accident/illness to? (Name & Position)

Telephone

3. 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
Left ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm Right ☐
Left ☐ Wrist ☐ Hand ☐ Finger(s) Right ☐
Left ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg Right ☐
Left ☐ Ankle ☐ Foot ☐ Toe(s) Right ☐

☐ Other:

Are you: ☐ Left Handed ☐ Right handed

4. Did the accident/illness happen on the employer's property or work site? ☐ yes ☐ no | Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):

5. Did it happen outside the Province of Ontario? ☐ yes ☐ no | If **yes**, indicate where (city, province/state, country):

6. Have you hurt this area(s) of your body before? ☐ yes ☐ no

7. Do you have any prior related WSIB/WCB claims? ☐ no ☐ yes - In Ontario ☐ yes - Outside Ontario

A guide to complete this form is available at www.wsib.on.ca

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C. Accident/Illness Dates & Details (continued)

8. If you had a sudden type of accident/illness, describe your injury and what happened to cause it (e.g. hurt lower back while lifting a 50 pound box, sprained left ankle when I slipped on a wet floor, used a new cleaner and immediately got a rash). Please indicate the size, weights and names of any objects involved.
or
If you had a gradual onset type of injury, describe your injury, the work that you do and what you believe caused your injury/condition.

start >

9. When did you first start to have problems with this injury/condition?

10. If you did not report this to your employer right away, please tell us the reason why.

11. If there were any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, give us their names & positions.

Name	Position
1.	
2.	

12. The Workplace Safety and Insurance Act requires your employer to give you a copy of the Employer's Report of Injury/Disease (Form 7).
Did you receive a copy of the Form 7? ☐ yes ☐ no

The Workplace Safety and Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer.

D. Health Care Information

Give your Health Professional your WSIB Claim number.

1. Did you get first aid or care at work ☐ yes ☐ no If **yes**, when dd mm yy and by whom (Name):

2. Where did you go for health care, for your injury, outside of work? **(Check all that apply)**

	Facility/Hospital (Name & Address)	Date of Visit (dd/mm/yy)		Date of Visit (dd/mm/yy)
☐ Nursing Station ☐ Emergency Department ☐ Admitted to Hospital			☐ Ambulance ☐ Health Professional Office ☐ Clinic	

3. Were you prescribed any medications/drugs? ☐ yes ☐ no

4. Were you referred for any other treatment or tests? ☐ yes ☐ no

5. Did you talk to your health professional about going back to regular or modified work? ☐ yes ☐ no If **yes**, were you given any work limitations? ☐ yes ☐ no

6. Did you tell your employer you went for medical treatment? ☐ yes ☐ no **If no, please tell your employer right away.**

If **yes**, when? dd mm yy and to whom? Name Position

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E. Lost Time & Return to Work

1. After the day of accident/illness:

start > ☐ I returned to work to my **regular job** and **did not** lose any time or pay.

☐ I returned to **modified duties** and **did not** lose any time or pay.

☐ I **lost time and/or pay** (e.g. regular pay, shift differential, bonuses, premiums, etc.).

→ Date you first lost time and/or pay — dd mm yy

2. If you lost time, have you returned to work? ☐ yes ☐ no

If **yes** ▶ Date of your return to work — dd mm yy ☐ regular work ☐ modified work

If **no** ▶ Did you discuss return to work with your employer? ☐ yes ☐ no

Does your employer have modified work? ☐ yes ☐ no

F. Earnings (Do not include overtime here)

1. Rate of pay: $ ..... per ☐ hour ☐ week ☐ other: .....

2. Usual number of pay hours: ..... per ☐ week ☐ other: .....

3. If you lost time from work after the day of accident/illness, did your employer continue to pay you? ☐ yes ☐ no

4. Have you applied for, or did you receive, any other benefits (money) while off work (e.g. EI benefits, sick benefits, social services, insurance, etc.). ☐ yes ☐ no

5. At the time of the accident/illness did you work for more than one employer? ☐ yes ☐ no

G. Declarations and Signature

By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the WSIB's "Functional Abilities Form for Planning Early and Safe Return 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 pages 1, 2, and 3 is true.

Signature	Date (dd/mm/yy)
Please print form & sign before returning to the WSIB	

If you are under the age of 16, your parent or guardian, must authorize the release of the functional abilities information.

Signature	Relationship:	Date (dd/mm/yy)	Telephone
Please print form & sign before returning to the WSIB			( )

Personal information about you will be collected throughout your claim under the authority of the *Workplace Safety and Insurance Act*, 1997. Your personal information will be used to administer your claim(s) and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, Canada Revenue Agency (CRA), and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax receipts and is collected under the authority of the Income Tax Act. Information may only be disclosed to the employer, external medical, vocational, and safety agencies, external payment and service providers, researchers, third parties for cost recovery purposes and others as authorized by the *Workplace Safety and Insurance Act* and the *Freedom of Information and Protection of Privacy Act*. Your name and telephone number may be disclosed to third party researchers conducting satisfaction surveys and focus groups. Incoming and outgoing calls may be recorded for quality assurance purposes. Questions about this collection should be directed to the decision maker responsible for your file or by calling 1-800-387-0750.

A more detailed PRIVACY STATEMENT for workers may be found at www.wsib.on.ca or by calling toll free at 1-800-387-0750.

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K. Additional Information

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