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

Claim Number

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 if 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		Worker Reference Number
Last Name: _____ First Name: _____ Address (number, street, apt., suite, unit): _____ City/Town: _____ Province: _____ Postal Code: _____		Is the worker covered by a Union/Collective Agreement? <input type="checkbox"/> yes <input type="checkbox"/> no
		Worker's preferred language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other
		Date of Birth: dd mm yy 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 OR <input type="checkbox"/> Account Number	Provide Number
Mailing Address	Rate Group Number	Classification Unit Code
City/Town	Province	Postal Code
Description of Business Activity	Does your firm have 20 or more workers? <input type="checkbox"/> yes <input type="checkbox"/> no	Telephone ()
Branch Address where worker is based (if different from mailing address - no abbreviations)		FAX Number ()
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 AM PM Date and hour reported to employer dd mm yy AM PM	2. Who was the accident/illness reported to? (Name & Position) _____ 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: (Please check all that apply) <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																																																							
5. Area of Injury (Body Part) - (Please check all that apply) <table border="0"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Teeth</td> <td><input type="checkbox"/> Upper back</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> <td>Left</td> <td>Right</td> </tr> <tr> <td><input type="checkbox"/> Face</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Lower back</td> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Hip</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Ankle</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Eye(s)</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Arm</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Thigh</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Foot</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Ear(s)</td> <td></td> <td><input type="checkbox"/> Pelvis</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Finger(s)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Knee</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Toe(s)</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td></td> <td></td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td><input type="checkbox"/> Lower Leg</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table>		<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"/>		
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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.																																																								

Claim Number

Please PRINT in black ink

Worker Name	Social Insurance Number
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C. Accident/Illness Dates and Details (Continued)

7. 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..).
8. Did the accident/illness happen outside the Province of Ontario? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes , where (city, province/state, country).
9. Are you aware of any witnesses or other employees involved in this accident/illness? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes , please provide name and work phone number _____
11. Are you aware of any prior similar or related problem, injury or condition? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes , please explain
12. If you have concerns about this claim, attach a written submission to this form. <input type="checkbox"/> submission attached	

D. Health Care

1. Did the worker receive health care for this injury? <input type="checkbox"/> yes <input type="checkbox"/> no	dd mm yy	2. When did the employer learn that the worker received health care?	dd mm yy
If yes , when : _____			
3. Where was the worker treated for this injury? (Please check all that apply)			
<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) _____ _____			

E. Lost Time - No Lost Time

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

F. Return To Work

1. Have you been provided with work limitations for this worker's injury? <input type="checkbox"/> yes <input type="checkbox"/> no	2. Has modified work been discussed with this worker? <input type="checkbox"/> yes <input type="checkbox"/> no	3. Has modified work been offered to this worker? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes , 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.
4. Who is responsible for arranging worker's return to work			
<input type="checkbox"/> Myself	<input type="checkbox"/> Other	Telephone	Ext.
Name _____		()	

Claim Number

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 <input type="text"/> Provincial <input type="text"/>	2. Vacation pay - on each cheque? <input type="checkbox"/> yes <input type="checkbox"/> no	Provide percentage _____ %
3. Date and hour last worked dd mm yy <input type="checkbox"/> AM <input type="checkbox"/> PM	4. Normal working hours on last day worked From <input type="checkbox"/> AM <input type="checkbox"/> PM To <input type="checkbox"/> AM <input type="checkbox"/> PM	5. Actual earnings for last day worked \$ _____
7. Advances on wages: Is the worker being paid while he/she recovers? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, indicate: <input type="checkbox"/> Full/Regular <input type="checkbox"/> Other _____		6. Normal earnings for last day worked \$ _____

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S	M	T	W	T	F	S
8	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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

▶ **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

