



**Workers' Compensation Board**

**Commission des accidents du travail**

360 Albert Street  
Suite 200  
Ottawa, Ontario K1R 7X7

*Ce formulaire est disponible en français sur demande.*

**Employer's Report of Accidental Injury or Industrial Disease**

Please see reverse for further details.

Employer Identification

Firm Name		Firm No.	Rate No.	Phone No.
Address		City/Town	Province	Postal Code
Plant, dept., or worksite where employed		Worker Reference No.	Miner's Certificate No.	

Worker Identification

Last Name	First Name	Sex	Area Code	Phone No.	Date of Birth
Address (no., street, apt.)			City/Town	Province	Postal Code
Date of Employment	Occupation at time of the injury and years of experience in that occupation	Yrs. Exp.	Language <b>B</b> English French	Other (if interpreter required)	Social Insurance No.
Date and hour of accidental injury	<b>C</b> Date and hour reported to employer	Name and address of attending physician(s)			

History of Accidental Injury or Industrial Disease

1. What happened to cause the injury?
2. Explain what the worker was doing and the effort involved.
3. Identify the size, weight and type of equipment or materials involved.
4. Describe injury, part of body involved and specify left or right side.
5. Where did the accident occur?
6. What conditions contributed to the accident and what steps have been taken to prevent recurrence?
7. Give the names and addresses of witnesses or persons having knowledge of the injury.

Please answer ALL questions - Explain "Yes" answers at the bottom of this section or attach a letter if necessary.

Claim Information

<b>E</b> 1. Is the injured person an owner, spouse of the employer, (sub) contractor or executive of the business?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	5. At the time of injury, was the worker doing work other than for the purpose of the employer's business?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
2. Did the accident happen outside Ontario? If yes, state Canadian province or country.	<input type="checkbox"/>	<input type="checkbox"/>	<b>G</b> 6. Was there any serious and wilful misconduct involved?	<input type="checkbox"/>	<input type="checkbox"/>
3. Was anyone not in your employ totally or partially responsible for the accident?	<input type="checkbox"/>	<input type="checkbox"/>	<b>H</b> 7. To your knowledge, has the worker had a previous similar disability?	<input type="checkbox"/>	<input type="checkbox"/>
<b>F</b> 4. Do you have any reason to doubt the history of injury?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have any information that the worker could have returned to work earlier?	<input type="checkbox"/>	<input type="checkbox"/>

Earnings and Lost Time Information

**K** Complete this section if the worker will be totally or partially disabled beyond the day of injury.

**L** Provide the average gross earnings on the day of injury and specify:  hourly  daily \$

Earnings for last day worked	Normal earnings for last day worked
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**K** Specify type of any additional benefits and weekly value \$

**L** From Revenue Canada TD1 form provide:

Net Claim For Exemption \$	Net Claim Code
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**M** Identify type of employment

Full time  Part time  Casual (Occasional)

Independent Operator  Apprentice

Date and hour last worked	Date and hour returned to work
Normal working hours on last day worked	Estimate length of time off work
From m To m	
<b>M</b> Enter worker's normal working days by: F = full day H = half day and total weekly pay hours.	S M T W T F S Total
If the worker worked after the first layoff, please enter dates.	From m To m
<b>N</b> If you have advanced or will be advancing anything to cover period of disability, give particulars including dates covered.	

**For W.C.B. Use**

<b>O</b> Authorized Signature	Official Title	Date day month year
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