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.

Claim No.

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. (A) | 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) English French | Other (if interpreter required) | Social Insurance No.

Date and hour of accidental injury m | (C) Date and hour reported to employer m | Name and address of attending physician(s)

History of Accidental Injury or Industrial Disease (D)

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.

Claim Information

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

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

Earnings and Lost Time Information

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

(J) 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

(K) Specify type of any additional benefits and weekly value $

(L) From Revenue Canada TD1 form provide:

Net Claim For Exemption $ | Net Claim Code

Identify type of employment

☐ Full time ☐ Part time ☐ Casual (Occasional)
☐ Independent Operator ☐ Apprentice

Date and hour last worked m | Date and hour returned to work m

Normal working hours on last day worked From m To m | Estimate length of time off work

(M) 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

(N) If you have advanced or will be advancing anything to cover period of disability, give particulars including dates covered.

For W.C.B. Use

(O) Authorized Signature | Official Title | Date day month year

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