OSSTF/FEESO

WSIB Fact Reporting Form

Worker's Name:_____ WSIB Claim#: _____

WSIB Case Manager Name & Number:_____

Lost Time / Health Care (circle appropriate) Accident Date:_____

Time of Accident:_____ Location of Accident: _____

To Whom Accident Reported:_____

Accident Reporting Date: _____

Date & Location of First Medical Attention:_____

Attending Physician: _____WSIB Form 8 Filed: ☐ YES ☐NO

Description of Accident/Incident:_____

_____

_____

Worker's Address:_____
Street name and number City Postal Code

Telephone # Home:_____Work:_____

Name of your Union Representative:_____

District Name & #: _____Bargaining Unit:_____

Workplace Location: _____Birth Date: _____
Day Month Year

Family Doctor: _____

Address:_____
Street name and number City Postal Code

Specialist:_____

Address:_____
Street name and number City Postal Code

Witnesses:_____

Witness Address:_____
Street name and number City Postal Code

Return to Work Approved by Physician? ☐Yes ☐No Date of Return to Work: _____

Restrictions? Please list: _____

Protecting and Enhancing Public Education
Protéger et faire avancer l'éducation publique

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