A LOCAL LEADER'S GUIDE TO THE WORKPLACE SAFETY AND INSURANCE BOARD (WSIB)

The OSSTF/FEESO Health and Safety/Workplace Safety and Insurance Act Committee (HS/WSIAC) would like to acknowledge the following who have been instrumental in putting this document together:

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October 2019
Protective Services Division

OSSTF/FEESO

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WORKPLACE SAFETY AND INSURANCE BOARD (WSIB)

Assisting members with applying for WSIB benefits can be complex, confusing and frustrating as you navigate your way through the complicated process and myriad of forms. We hope this basic summary will assist you in making the process less stressful for the members you are supporting and for yourself, as a local leader. The Provincial Office can also provide you with information regarding the process, as well as the rights and responsibilities of each of the workplace parties.

BASIC BENEFITS

WSIB entitlement provides for two (2) forms of compensation in the event of a workplace injury:

1. **LOE—Loss of Earnings (wage replacement)**

   If a member loses time from work due to a workplace accident, they may be entitled to LOE benefits. LOE is paid at 85 per cent (85%) of the net average salary. There is a yearly maximum salary cap ($90,300 for 2018). If permitted under the Collective Agreement, the WSIB benefit may be topped up and benefits are non-taxable.

2. **HCB—Health Care Benefits (treatment expenses)**

   The WSIB pays for most medical treatments related to the workplace accident (medications, physiotherapy, chiropractic care, etc.). The WSIB has established caps for most health care benefits.

Another form of compensation that may occur is a Non-Economic Loss (NEL) Award. This is a lump sum of money that may be granted where there is a Permanent Impairment (PI) as a result of a workplace accident. This impairment does not necessarily prevent an injured member from earning full wages. It is for general pain and suffering.

FILING A WSIB CLAIM

It is important to impress upon members that all accidents/injuries that occur on the worksite or that arise out of and in the course of employment should be reported to the employer. Ensure that the member completes an employer accident report in writing and submits it to their supervisor (usually the principal, in a typical school setting). This does not mean, however, that every injury is reported to the WSIB. The member, or the employer, only needs to report the accident to the WSIB if: you lose time from work due to the injury, if the injury necessitates medical attention, or if some form of health care is required (i.e. physiotherapy). If you become aware of a member who has had an incident/injury, ensure they seek medical attention immediately, if required. Many of our members have had difficulty with WSIB claims because they did not seek medical attention soon enough. For an initial steps checklist, see Appendix G.
When a member is injured at work and it may be a WSIB claim, encourage and support the member to start the process by completing Form 6 (see below) to record the details of the injury. If the worker needs to seek medical attention, ensure Form 8 (see below) is completed by the health care provider. Finally, the employer is responsible for completing Form 7 (see below).

OFFICIAL REPORTING FORMS

Form 6—Worker's Report (see Appendix A)

The member must report the accident to the WSIB through Form 6. This form is their opportunity to describe the workplace accident and/or injury suffered. Form 6 will also trigger the start of a WSIB claim. This form is available online at www.WSIB.on.ca. Any information provided on this form should be accurate and the WSIB will expect that it is consistent with the health care provider's Form 8. The member is required to provide a copy of Form 6 to the employer. When claiming for Chronic Mental Stress (CMS), Post Traumatic Stress Disorder (PTSD) or Traumatic Mental Stress (TMS), members are advised to provide additional documentation with Form 6. This documentation should provide the narrative of the workplace events, names of witnesses and any related reports of incidents giving rise to the mental stress injury. It can be extremely challenging and traumatic for members to complete the WSIB documentation, so local leaders should be prepared to assist in completing the forms and supporting documentation with as much detail as possible. Ensure the member provides you with a copy of Form 6 and any supporting documentation for your files.

Form 7—Employer's Report (see Appendix B)

Form 7 is the employer's reporting of the accident to the WSIB. Form 7 comes in triplicate and the member has the right to receive a copy from the employer. Injured workers have no ability to revise the employer's Form 7. Form 7 will trigger the start of the claim process with the WSIB, if Form 6 has not already been completed. You should encourage the member to provide you with a copy of Form 7 for your files.

Form 8—Health Professional's Report (see Appendix C)

When a member seeks medical attention for a work-related accident, the treating health care professional is obligated to complete and submit Form 8 to the WSIB (remind the worker to keep a copy of the form as well). Form 8 is the health care professional's report of the accident based upon the physical examination done at the time. Form 8 will also trigger the start of the claim process with WSIB, if Form 6 or 7 have not been submitted. There is a separate form, CMS8, for CMS.

Chronic Mental Stress Claims—CMS (see Appendix D)

New WSIB Entitlement

Effective January 2018, Ontario workers have entitlement to WSIB benefits for workplace chronic mental stress. To be eligible for WSIB benefits, the CMS injury must be predominantly caused by a substantial work-related stressor. Stress caused by an employer's management decisions is generally not compensable. More information about the WSIB's CMS policy (15-03-14) is available on the WSIB website www.WSIBresources.ca/CMSPolicyPDFS/150314advanceversion.pdf.

Functional Abilities Form—FAF (see Appendix E)

An injured worker is obligated to consent to the release of functional abilities information, in order for the WSIB to adjudicate a claim and/or determine return to work capabilities. This information outlines a member's restrictions and limitations due to the workplace injury. The form is provided to the employer and used to assess whether you can return to your job and/or whether accommodations would enable you to return.

The FAF is normally given to the member by the employer for completion by the physician. The information is then released to the employer. Some employers will request permission to write to a member's doctor for additional information or to speak directly with the doctor regarding an absence. This should never

be granted and a member should never sign away their right to privacy by giving the employer full and open-ended access to a member's medical history. If in doubt about what is being requested of the member, please consult the Provincial Office.

Functional abilities information may be indicated on a WSIB Functional Abilities Form or separately as part of the physician's Form 8.

NOTE: The WSIB FAF is not the same as the Appendix B FAF from the Central Collective Agreement, with respect to the documentation employers need to adjudicate sick leave benefits.

THE IMPORTANCE OF MEDICAL EVIDENCE

Medical evidence is the key to a successful claim. Lack of medical evidence is often the reason for negative decisions. There are a variety of reasons that a claim may be denied or benefits terminated, such as:

- lack of medical documentation to support the claim
- medical documentation in the file is not current
- delay in reporting an accident to the employer and/or filing a WSIB claim
- all injured parts of the body are not listed on Form 6, Form 7 or Form 8
- delay in seeking medical attention for the injury
- no proof of accident/illness
- non-co-operation in a return to work plan (by the member)
- factual disputes about the reported accident

A claim that is filed with the proper information is often paid without unreasonable delay. If not reported properly, however, numerous problems can arise. The member must keep in regular contact with the treating health care practitioner in order to help establish continuity of medical treatment and to demonstrate the seriousness of the injury/accident. Recommend to the member that they should obtain appropriate medical care for each injury or body part affected. Encourage the member to keep a journal of medical appointments and symptoms, as this will assist in the future, if the claim needs to go through the WSIB appeal process.

Medical evidence is often needed to address the following issues:

- whether the condition is disabling
- what medical restrictions or limitations remain
- whether the disabling condition arose out of the workplace accident
- what additional treatment or health care is needed

While a family physician's report will always be important in a WSIB claim, the WSIB relies heavily on the opinion of a specialist who has expertise in the area of the illness/injury. It is crucial that such an opinion be obtained as soon as possible, particularly if the injury/disease is complex. A specialist can only comment on their area of expertise.

The WSIB looks for objective medical evidence in assessing the merits of a claim. Objective evidence includes test results, medications, x-rays, CT scans, MRIs and other medical tests. These are needed to help confirm the connection between the injury/disease and the workplace accident, along with the severity/disabling nature of the injury. The onus is on the injured member to provide the WSIB with the appropriate medical documentation. Remind the member to get written documentation from each visit/treatment session and to keep everything together in a file.

Return to Work (RTW)/Medical Accommodation

Under WSIB legislation, members are obligated to co-operate in any RTW plan or discussions. The WSIB pursues early and safe return to work options at the earliest opportunity. The member may be expected to return to work even though they are experiencing residual effects of the injury. Failure to co-operate in RTW plans may result in the denial or suspension of your benefits.

The employer has obligations to accommodate an employee's return to work. These obligations are defined in the *Workplace Safety and Insurance Act*, the Ontario Human Rights Code and often the Collective Agreement. The limit of this obligation is accommodation, which would cause the employer undue hardship, and the threshold for undue hardship is set very high. As a local leader, you may need to push the employer for appropriate RTW plans, if they try to claim undue hardship or indicate they cannot accommodate a member.

To return to work, a member is required to provide the employer with a medical certificate stating they are cleared to return to work. A member must give the employer prior notice of the date of return. RTW discussions should take place prior to any return.

If the member requires a medical accommodation, an FAF will likely be needed to produce a list of medical restrictions and limitations, as outlined by the treating physician. If these have not already been provided through the WSIB process, you should discuss a RTW plan with your doctor(s) prior to accepting an employer's offer of modified work. Members should never accept a RTW plan without consulting you, as the local leader, and members should never attend RTW meetings alone.

Under the *Labour Relations Act*, the union has a Duty of Fair Representation (DFR) to its members with respect to RTW issues, including requests for medical accommodation. The union must participate in RTW plans and/or medical accommodations (see WSIB policy 19-02-01). Members have a right to union representation throughout the entire process. As the local representative, you should regularly advocate on behalf of members returning from medical leaves, including WSIB-related leaves. Contact the Provincial Office for support if needed.

A medical accommodation is a need based on medical documentation and **not** a job preference.

POSSIBLE RETURN TO WORK OUTCOMES FOR MEMBERS

Every RTW plan is different and each case is based on a member's medical documentation. In general, the member might return to:

1. Their own assignment;
2. Their own assignment with modifications in duties or hours;
3. The same work location—with a different but comparable temporary assignment;
4. The same work location—with a suitable temporary assignment; and
5. A different work location—with a different job assignment.

The physician or specialist does not decide what type of assignment a member should have. The workplace parties, which include the employer, the union (local leader), and the member are responsible for the process and all parties must have input. Employers will commonly search for positions which are vacant, or positions may be created to meet the identified restrictions and limitations.

WORK REINTEGRATION PROGRAM

RTW issues and RTW plans are dealt with under the WSIB's Work Reintegration Program. An injured member, you (local leader) and the employer are obligated to co-operate in any RTW plan or meeting. There is a mandatory WSIB RTW meeting that must take place no later than 12 weeks following the date of the workplace accident. The member is expected to attend this meeting even if they are not fully recovered or ready to RTW. Failure to attend such a meeting may result in the suspension or termination of benefits.

A WSIB RTW Specialist will often facilitate the meeting, although an employer representative may also serve this role. The RTW Specialist or the employer reports the outcome of the meeting to the WSIB Case Manager (CM). The ultimate decision to accept/approve the RTW plan rests with the CM.

A RTW plan is based on the restrictions and limitations as outlined by the treating health care professional(s). The start of any RTW discussions must be with the pre-injury job in mind. As the local leader, you should always be in attendance at any WSIB RTW meeting. Ensure that you speak up on behalf of the member, if you believe a RTW or reintegration program is not appropriate for the member. At the end of the meeting, the meeting facilitator will make a report to the WSIB CM, outlining the specific elements of the RTW plan agreed upon by the workplace parties.

Although not specifically addressed under WSIB policies, applying for WSIB benefits brings with it a duty for the member to mitigate their circumstances while awaiting benefit entitlement. This means they are expected to try and take whatever measures they can to help reduce the effects of the workplace accident and which would assist them in getting back to work. Remember, they do not have to be fully recovered in order to RTW.

TIME LIMITS

There are time limits for appealing decisions made at the WSIB level and at the Workplace Safety and Insurance Appeals Tribunal (WSIAT). It is critical that all the applicable timelines associated with the claim are met. It is vital that, as a local leader, you keep track of key timelines for each of the files you are working on. A missed timeline puts a member's benefit entitlement in serious jeopardy.

If a claim has been denied, the member will receive written correspondence from the WSIB indicating any applicable time limit. Upon receipt of that correspondence, an Intent to Object (ITO) Form must be submitted to the WSIB within the specified time limit, if you wish to preserve your right to appeal a negative decision. This is typically when you should be contacting the Provincial Office for direction and assistance (see D/BU—Policy for Approval of Legal Assistance, Appendix F, Appendix F).

APPEALING A NEGATIVE DECISION

If a claim has been denied or terminated and you, or the member, do not agree with the decision, the member has the right to appeal.

As indicated above, the member will receive a written decision from the WSIB explaining why entitlement has been denied. Once an ITO has been submitted to the WSIB, (see Time Limits above), two (2) things can happen:

1. If there is new information to submit with the ITO Form, the WSIB CM can reconsider this information and provide you with the outcome of that review.
2. If there is no new information submitted with the ITO Form, an Appeals Readiness Form (ARF) will be sent with a copy of your claim file, along with an Objection to Employer Access Form.

If the CM does not change the decision after reviewing the ITO Form and new information provided for reconsideration, the submission of the ARF starts the formal appeal process. By this time, you should have made a request for legal assistance, as per the OSSTF/FEESO policy, and advice/support from Provincial Office is available. While there is no time limit for returning the ARF, there are very strict rules as to when and under what conditions the form may be submitted. Please carefully review the Worker Instruction Sheet that goes with the ARF but also consult Provincial Office before considering its completion. It is important to note that no WSIB benefits will be paid unless/until a WSIB appeal is successful.

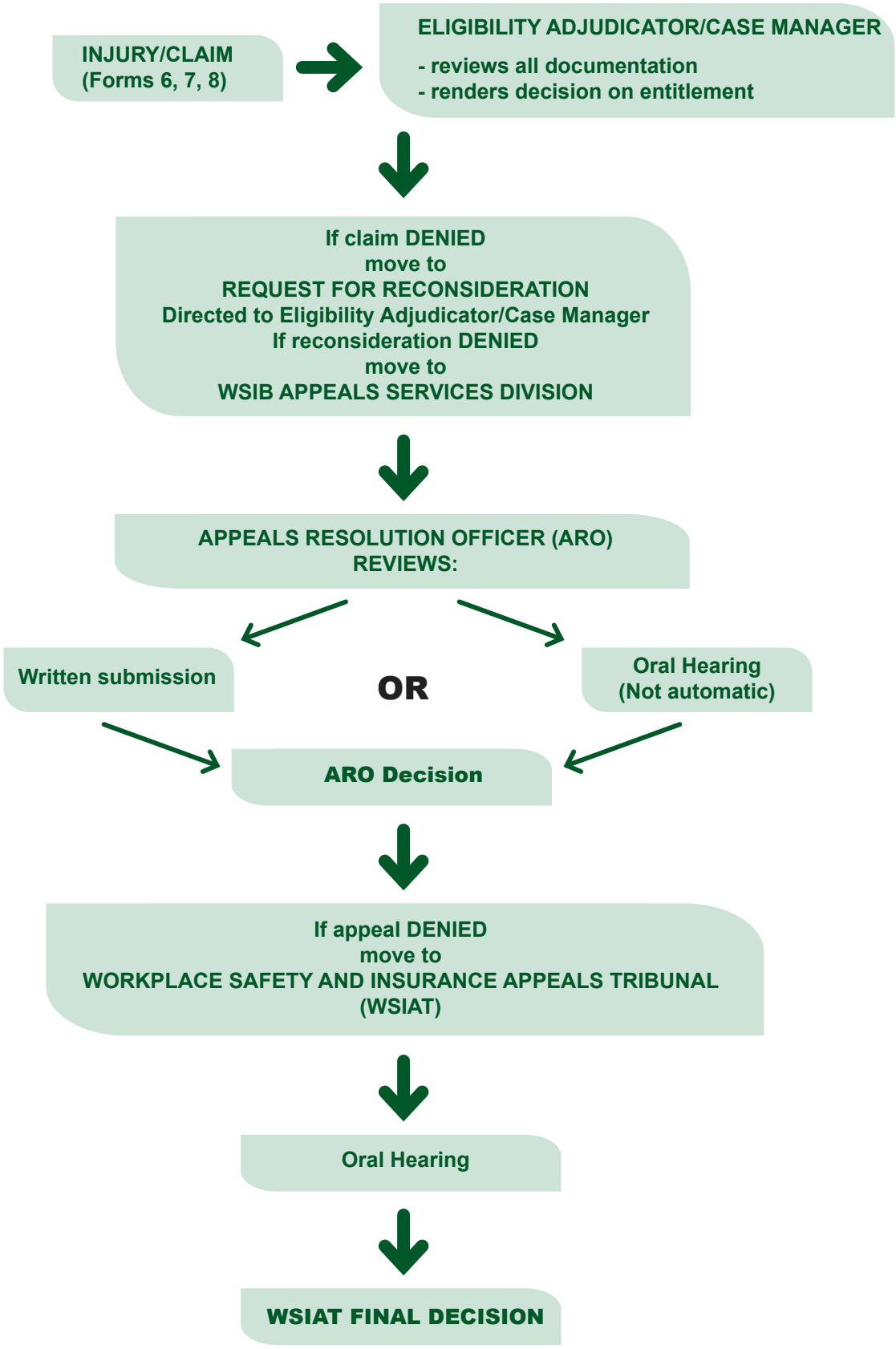
APPEALS RESOLUTION OFFICER

When an appeal is referred to the Appeals Services Division, a decision will be rendered by an Appeals Resolution Officer (ARO). An appeal may be addressed via a written submission or an oral hearing. An oral hearing is not provided in every case. The WSIB will determine if an oral hearing is necessary.

WORKPLACE SAFETY & INSURANCE APPEALS TRIBUNAL

If the ARO upholds the decision to deny or terminate the claim, you may request that the claim proceed to the final level of appeal with the WSIAT. The appeal format consists of an oral hearing only. The decision made at the WSIAT is final.

WSIB SYSTEM


INJURY/CLAIM
(Forms 6, 7, 8)
ELIGIBILITY ADJUDICATOR/CASE MANAGER
- reviews all documentation
- renders decision on entitlement
If claim DENIED
move to
REQUEST FOR RECONSIDERATION
Directed to Eligibility Adjudicator/Case Manager
If reconsideration DENIED
move to
WSIB APPEALS SERVICES DIVISION
APPEALS RESOLUTION OFFICER (ARO)
REVIEWS:
Written submission
OR
Oral Hearing
(Not automatic)
ARO Decision
If appeal DENIED
move to
WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL
(WSIAT)
Oral Hearing
WSIAT FINAL DECISION

WSIB AND SICK LEAVE

If a member suffers a workplace injury and is medically unable to RTW, their salary will be suspended and they will begin to access sick leave credits. Once entitlement is granted by the WSIB, the absence will be recorded as WSIB related. As the local leader, you must ensure that the sick leave credits are returned to the member at the appropriate rate, as per the Collective Agreement.

The WSIB pays at a rate of 85 per cent (85%) of a worker's net average earnings. Under our current Central Agreement, there are rules regarding sick leave and top-up for WSIB purposes. WSIB top-up is limited to members who were eligible to use unused sick leave credits as of August 31, 2012. Top-up shall be paid in accordance with the Collective Agreement or board policy as of August 31, 2012 and is subject to a maximum time period of four years and six months. Please contact your local Protective Services field secretary for the assistance with the applicable top-up protocol for your employer.

WSIB AND PENSION

Members receiving WSIB benefits continue to be active members of the pension plan. LOE benefits are pensionable. Members with longstanding WSIB claims are advised to contact the pension plan to confirm the process for making the required contributions.

FINANCIAL ASSISTANCE

It may take some time for a member to receive a decision from the WSIB with respect to the claim. No WSIB benefits will be paid until entitlement has been granted by the WSIB. If a member has exhausted sick credits but has not yet qualified for WSIB benefits, they may qualify for financial aid through the following government programs:

Employment Insurance (EI)

These benefits may be paid for a maximum of 15 weeks after the expiration of sick leave. They must have accumulated 600 insurable hours in the 52 weeks preceding the claim. There is an application process that requires a Record of Employment (ROE) from the employer, along with a medical certificate signed by the doctor confirming the member is medically unable to work. The ROE is completed by the employer after the last day of paid work and the exhaustion of any sick leave. For more information please see A Member's Guide to Employment Insurance at www.osstf.on.ca.

Ontario Disability Support Program (ODSP)

This form of social assistance may include financial assistance provided to a person with a disability, as well as accommodation, basic living expenses, prescription drugs and basic dental care. There are eligibility requirements. For more information, please check the website at www.mcss.gov.on.ca.

If a WSIB claim is approved, a member will be expected to repay any monies received from EI or ODSP.

CONCURRENT WSIB AND LONG TERM DISABILITY (LTD) CLAIMS

In the event of a workplace accident, a member may file a WSIB claim. If it is anticipated that the member is going to be away from work for a lengthy period of time due to the work-related injury, it is recommended that they also apply for LTD. WSIB and LTD claims can run concurrently, though a member will not generally receive benefits from both for the same period of time.

WSIB will be the first payor. If the WSIB claim is denied and the LTD claim has been approved, LTD can be activated so that the member is not without some income. If they are also applying for LTD, it is imperative that they do not miss the deadline for filing an LTD claim.

FREQUENTLY USED WSIB ACRONYMS

ACT (WSIA)	Workplace Safety and Insurance Act
ADJUDICATE	Decide
A/E	Accident Employer
ARO	Appeals Resolution Officer
CA	Claims Adjudicator
CM	Case Manager
COMP	Compensation
CPP	Canada Pension Plan
DOA	Date of Accident
EMP	Employer
ENT	Entitlement
ESRTW	Early and Safe Return to Work
FAE	Functional Assessment Evaluation
FAF	Functional Abilities Form
FU	Follow-Up
HCB	Health Care Benefits
IE	Injured Employee
INJ	Injury
IW	Injured Worker
LDW	Last Day Worked
LMR	Labour Market Re-entry
LO	Lay Off, Laid Off
LOE	Loss of Earnings
MC	Medical Consultant
MMR	Maximum Medical Recovery
MVA	Motor Vehicle Accident
MW or Mod. Work	Modified Work

NCM	Nurse Case Manager
NEL	Non-Economic Loss
NFA	No Further Action
NLT	No Lost Time
NON COMP	Non-Compensable
ODD	Occupational Disease Department
OHCOW	Occupational Health Clinics for Ontario Workers
O/S	Outstanding
PD	Permanent Disability
PI	Permanent Impairment
PENS	Pension(s)
PPD	Permanent Partial Disability
RC	Rehabilitation Counsellor
REC	Regional Evaluation Centre
REO	Re-Open (claim)
REP	Representative
RMA	Regional Medical Advisor
RTW	Return to Work
RX	Prescription
TRIBUNAL	Workplace Safety and Appeals Tribunal
WSIAT	Workplace Safety and Appeals Tribunal
WSIB	Workplace Safety and Insurance Board

WSIB FORM 6—APPENDIX A

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

A. Worker Information

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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Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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

Claim Number

Please PRINT in black ink

Last Name	First Name	Social Insurance Number

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.

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			☐ Ambulance	
☐ Emergency Department			☐ Health Professional Office	
☐ Admitted to Hospital			☐ 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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Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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

Claim Number

Please PRINT in black ink

Last Name	First Name	Social Insurance Number

E. Lost Time & Return to Work

1. After the day of accident/illness:

- ☐ 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)

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
			(

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 statements and is collected under the authority of the *Income Tax Act*. Information may only be disclosed to the employer, external medical consultants, external 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 parties 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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6 Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in black ink

Last Name	First Name	Social Insurance Number

K. Additional Information

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

0006A4

WSIB FORM 7—APPENDIX B

wsib cspaat ONTARIO

Mail To:
200 Front Street West
Toronto ON M5V 3J1

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

Please PRINT in black ink

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: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name | First Name

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

City/Town | Province | Postal Code

Is the worker covered by a Union/Collective Agreement? ☐ yes ☐ no

Worker Reference Number

Worker's preferred language ☐ English ☐ French ☐ Other

Date of Birth dd mm yy

Telephone

Sex ☐ M ☐ 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: ☐ Firm Number **OR** ☐ Account Number — Provide Number

Mailing Address

Rate Group Number

Classification Unit Code

City/Town | Province | Postal Code | Telephone

Description of Business Activity

Does your firm have 20 or more workers? ☐ yes ☐ no

FAX Number

Branch Address where worker is based (if different from mailing address - no abbreviations)

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:
- ☐ Sudden Specific Event/Occurrence
- ☐ Gradually Occurring Over Time
- ☐ Occupational Disease
- ☐ Fatality

4. Type of accident/illness: **(Please check all that apply)**
- ☐ Struck/Caught
- ☐ Overexertion
- ☐ Repetition
- ☐ Fire/Explosion
- ☐ Fall
- ☐ Harmful Substances/Environmental
- ☐ Assault
- ☐ Other
- ☐ Slip/Trip
- ☐ Motor Vehicle Incident

5. Area of Injury (Body Part) - **(Please check all that apply)**
- ☐ Head
- ☐ Face
- ☐ Eye(s)
- ☐ Ear(s)
- ☐ Other
- ☐ 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 ☐ ☐ ☐

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.**

wsib cspaat ONTARIO

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

Claim Number

Please PRINT in black ink

Worker Name	Social Insurance Number

C. Accident/Illness Dates and Details (Continued)

7. Did the accident/illness happen on the employer's premises (owned, leased or maintained)? ☐ yes ☐ no
Specify where (shop floor, warehouse, client/customer site, parking lot, etc..).

8. Did the accident/illness happen outside the Province of Ontario? ☐ yes ☐ no
If **yes,** where (city, province/state, country).

9. Are you aware of any witnesses or other employees involved in this accident/illness? ☐ yes ☐ 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? ☐ yes ☐ no
If **yes,** please provide name and work phone number .....

11. Are you aware of any prior similar or related problem, injury or condition? ☐ yes ☐ no
If **yes,** please explain

12. If you have concerns about this claim, attach a written submission to this form. ☐ submission attached

D. Health Care

1. Did the worker receive health care for this injury? ☐ yes ☐ no
If **yes,** when : dd mm yy

2. When did the employer learn that the worker received health care? dd mm yy

3. Where was the worker treated for this injury? **(Please check all that apply)**
☐ On-site health care ☐ Ambulance ☐ Emergency department ☐ Admitted to hospital ☐ Health professional office ☐ Clinic
☐ 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:**
☐ Returned to his/her **regular job** and **has not** lost any time and/or earnings. **(Complete sections G and J).**
☐ Returned to **modified work** and **has not** lost any time and/or earnings. **(Complete sections F, G, and J).**
☐ **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 ☐ regular work ☐ modified work

2. This Lost Time - No Lost Time - Modified Work information was confirmed by: Telephone Ext.
☐ Myself ☐ Other
Name .....

F. Return To Work

1. Have you been provided with work limitations for this worker's injury? ☐ yes ☐ no

2. Has modified work been discussed with this worker? ☐ yes ☐ no

3. Has modified work been offered to this worker? ☐ yes ☐ no
If **yes,** was it ☐ Accepted ☐ Declined
☐ 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 Telephone Ext.
☐ Myself ☐ Other
Name .....

wsib cspaat ONTARIO

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

Claim Number

Please PRINT in black ink

Worker Name	Social Insurance Number

G. Base Wage/Employment Information - (Do not include overtime here)

1. Is this worker **(Please check all that apply)**

- ☐ Permanent Full Time
- ☐ Permanent Part Time
- ☐ Temporary Full Time
- ☐ Temporary Part Time
- ☐ Casual/Irregular
- ☐ Seasonal
- ☐ Contract
- ☐ Student
- ☐ Unpaid/Trainee
- ☐ Other
- ☐ Registered Apprentice
- ☐ Optional Insurance
- ☐ Owner Operator or (Sub) Contractor

2. Regular rate of pay $ _____ per ☐ hour ☐ day ☐ week ☐ other _____

H. Additional Wage Information

1. Net Claim Code or Amount — Federal _____ Provincial _____

2. Vacation pay - on each cheque? ☐ yes ☐ no — Provide percentage _____ %

3. Date and hour last worked — dd mm yy ☐ AM ☐ PM

4. Normal working hours on last day worked — From ☐ AM ☐ PM To ☐ AM ☐ PM

5. Actual earnings for last day worked $ _____

6. Normal earnings for last day worked $ _____

7. Advances on wages: Is the worker being paid while he/she recovers? ☐ yes ☐ no If yes, indicate: ☐ Full/Regular ☐ Other _____

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	Commission	Commission	Commission	Commission
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.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

▶ **Example:** Monday to Friday, 40 hours

S	M	T	W	T	F	S
	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

▶ **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

wsib cspaat ONTARIO

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

Claim Number

Please PRINT in black ink

Worker Name	Social Insurance Number

K. Additional Information

THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER

WSIB FORM 8—APPENDIX C

wsib cspaat ONTARIO

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

Claim Number (If known)

8 Health Professional's Report (Form 8)

A. Patient and Employer Information - (Patient to complete Section A)

Last Name	First Name	Init.	Sex
			☐ M ☐ F

Address (no., street, apt.)	City/Town	Prov.	Postal Code
		ON	

Telephone	Social Insurance No.	Date of Birth (dd mm yyyy)	Language
			☐ Eng. ☐ Fr. ☐ Other

Employer Name

The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the Workplace Safety and Insurance Act. The Social Insurance Number may be used to identify workers and to issue income tax information statements as authorized by the Income Tax Act. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.

B. Incident Dates and Details Section

1. How did the injury/reinjury or illness occur at work?

Occupation

Date of incident/or when did the symptoms start? (dd mm yyyy)

C. Clinical Information Section - (Please check all that apply)

1. Area of Injury/Illness

☐ Brain ☐ Head ☐ Face ☐ Eyes ☐ Other: _____

☐ Ears ☐ Teeth ☐ Neck ☐ Chest

☐ **Upper back** ☐ **Lower back** ☐ Abdomen ☐ Pelvis

	Left	Right
Shoulder	☐	☐
Arm	☐	☐
Elbow	☐	☐
Forearm	☐	☐
Wrist	☐	☐
Hand	☐	☐
Fingers	☐	☐
Hip	☐	☐
Thigh	☐	☐
Knee	☐	☐
Lower Leg	☐	☐
Ankle	☐	☐
Foot	☐	☐
Toes	☐	☐

2. Description of Injury/Illness Physical Examination Findings

☐ Pain at rest/Night Pain

Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10

☐ Abrasion
☐ Amputation
☐ Bite
☐ Burn
☐ Contusion/Hematoma/Swelling
☐ Crush Injury

☐ Disc Herniation
☐ Dislocation
☐ **Fall from Height**
☐ Foreign Body
☐ **Fracture**
☐ Hernia
☐ Infection

☐ Inflammation
☐ Internal Joint Derangement
☐ Joint Effusion
☐ Laceration
☐ **Neurological Dysfunction**
☐ Psychological
☐ Puncture (non-needlestick)

☐ Repetitive Strain Injury
☐ Spinal Cord Injury
☐ Sprain/Strain
☐ **Surgical Intervention**
☐ Tendonitis/Tenosynovitis
☐ ▼ Range of Motion

☐ Other _____

Exposure/Illness

☐ Asthma
☐ Cancer
☐ Fumes - Inhalation
☐ Hand-arm Vibration
☐ Hearing Loss
☐ Infectious Disease
☐ Needle Stick
☐ Poisoning/Toxic Effects
☐ Skin Condition

3. Are you aware of any pre-existing or other conditions/factors that may impact recovery? ☐ yes ☐ no

If yes, describe _____

4. Diagnosis

D. Treatment Plan

1. What is the treatment plan (type of treatment, duration) including prescribed medications?

2. To be completed by physicians only.

Work Injury/Illness Medications	Dose	Frequency	Duration	Work Injury/Illness Medications	Dose	Frequency	Duration
1.				3.			
2.				4.			

3. Investigations & Referrals:

☐ None ☐ Labs ☐ Xrays ☐ CT Scan ☐ MRI ☐ EMG ☐ Ultrasound ☐ Other _____

☐ FP/GP
☐ Specialist/ Specialty _____
☐ Chiropractor

☐ Occupational Health Centre
☐ Occupational Therapist
☐ Other _____

☐ Physiotherapist
☐ Psychologist

Would the patient benefit from the following referrals?
☐ Specialty Clinic
☐ Regional Evaluation Centre (REC)

Name of Referral or Facility (if known) | Telephone | Appointment Date (dd mm yyyy)

E. Billing Section

Health Professional Designation
☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class)

Service Code **8M** | WSIB Provider ID

HST Registration No.	HST Amount Billed (if applicable)	Service Code	Your Invoice No.	Service Date (dd mm yyyy)
	$	**ONHST**		

Health Professional Name (please print) | Address

Telephone | Fax

wsib cspaat ONTARIO

Claim Number (If known)

8 Health Professional's Report (Form 8)

Return To Work Information

Once completed, please ensure that a copy of this page only is provided to the worker.

Last Name	First Name	Init.	Birth Date dd mm yyyy

Area(s) of Injury(ies)/Illness(es)

Date of Incident dd mm yyyy

F. Return To Work Information - Must be completed by a Health Professional

When work injury/illness occurs, focus on return to usual activity including return to safe and appropriate work is best practice. Most workers who experience soft tissue injury are able to remain at work.

1. Have you discussed return to work with your patient? ☐ yes ☐ no

2. ☐ **This worker can resume Regular duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

☐ **This worker can begin Modified duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

☐ **This worker is not able to work because of the workplace injury/illness.**

Please provide explanation _____

3. Please indicate the worker's status and functional abilities in relation to the workplace injury and diagnosis.

A. Full Functional Abilities ☐

B. Worker Functional Abilities

	Able to	Not Able to		Able to	Not Able to		Able to	Not Able to
Bend/Twist	☐	☐	Operate Heavy Equipment	☐	☐	Stand	☐	☐
Climb	☐	☐	Operate a Motor Vehicle	☐	☐	Use of Public Transportation	☐	☐
Kneel	☐	☐	Push/Pull	☐	☐	Use of Upper Extremities	☐	☐
Lift	☐	☐	Sit	☐	☐	Walk	☐	☐

C. Other Limitations: eg. Environmental Conditions, Medication, Use of Protective Equipment.

Please describe: _____

4. From the date of this assessment, the above limitations will apply for approximately:

☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Follow-up Appointment

☐ None required ☐ As Needed Date of next appointment dd mm yyyy

Health Professional's Name (Please print)	Address	
Health Professional's Signature	Telephone	Service Date dd mm yyyy

G. Worker's Signature

By signing below I am authorizing the above noted health professional, who is treating me, to provide my employer with a copy of this page outlining my functional abilities. I understand a copy will be sent to the Workplace Safety and Insurance Board (WSIB) by my health professional.

Signature	Date dd mm yyyy

Once completed, please ensure that a copy of this page only is provided to the worker.

WSIB CMS FORM 8—APPENDIX D

wsib cspaat ONTARIO

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

Claim Number (If known)

Health Professional's Report for Occupational Mental Stress (Form CMS8)

A. Patient and Employer Information (Patient to complete Section A)

Last Name	First Name	Init.	Sex ☐ M ☐ F
Address (number, street, apt.)	City/Town	Prov.	Postal Code
Telephone	Date of Birth dd mm yyyy	Language ☐ English ☐ French ☐ Other	
Employer Name	Supervisor/Contact Name	Telephone	
Employer Address	Patient's Job Title/Occupation		

The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the Workplace Safety and Insurance Act. Questions should be directed to the decision maker responsible for the file or toll free at 1-800-387-0750.

B. General Section

1. Is your patient indicating that their psychological condition is due to work? ☐ yes ☐ no

Date patient first sought medical care for psychological condition dd mm yyyy	Date of onset of symptoms/signs dd mm yyyy
2. Does your patient continue to exhibit the psychological condition? ☐ yes ☐ no	If no, indicate date of last symptoms or when symptoms resolved dd mm yyyy

3. What is your understanding of the work-related situation(s) resulting in the reported psychological condition? Please explain.

C. Clinical Information Section

1. Document the diagnosis and criteria for the DSM diagnosis, if met.

Diagnosis (provide DSM diagnosis if possible):	DSM criteria for the diagnosis, if met:

2. Are you aware of any pre-existing or co-existing psychological conditions, or other relevant/contributing factors?

☐ yes ☐ no ☐ unknown

If yes, please describe briefly (e.g. diagnosis, date of onset, previous treatment if known):

D. Treatment Plan

1. What is the treatment plan (including type of treatment, duration, prescribed medications and any recommended referrals)?

E. Billing Section

Health Professional Designation ☐ Physician ☐ Nurse Practitioner ☐ Other _____				Service Code **8CMS**	WSIB Provider ID
HST Registration No.	HST Amount Billed (if applicable) **$**	Service Code **ONHST**	Your Invoice No.	Service Date dd mm yyyy	
Health Professional Name (please print)			Address		
Telephone			Fax		

wsib cspaat ONTARIO

Claim Number (If known)

Health Professional's Report for Occupational Mental Stress (Form CMS8)

Once completed, please ensure that a copy of this page only is provided to the patient.

Last Name	First Name	Init.	Date of Birth dd mm yyyy

Date patient first sought medical care for psychological condition dd mm yyyy

F. Return To Work Information - Must be completed by a Health Professional

When work injury/illness occurs, focus on return to usual activity including return to safe and appropriate work is best practice.

1. **Has the patient lost time from work as a result of the psychological condition?** ☐ yes ☐ no
   If no, go to question 4.

2. **If the patient is not at work,**

A. ☐ **This patient can resume Regular duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

B. ☐ **This patient can begin Modified duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

C. ☐ **This patient is not able to work because of the psychological condition.**
Please provide explanation:

What would need to be in place for your patient to return to work in any capacity? Please list:

3. **With respect to your patient's psychological condition, please describe your patient's functional abilities to facilitate work accommodations.**

A. ☐ **Full functional abilities, no accommodations required.**

B. ☐ **Patient has impairments in function (social, occupational, other), accommodations are required. Please describe:**

C. ☐ **Other limitations. Please describe:**

4. **Your patient's next follow-up appointment**
☐ None required ☐ As Needed ☐ Scheduled, please indicate date

Date of next appointment dd mm yyyy

Health Professional's Name (Please print)	Address	
Health Professional's Signature	Telephone	Service Date dd mm yyyy

G. Worker's Signature

By signing below I am authorizing the above noted health professional, who is treating me, to provide my employer with a copy of this page outlining my functional abilities. I understand a copy will be sent to the Workplace Safety and Insurance Board (WSIB) by my health professional.

Signature	Date dd mm yyyy

Once completed, please ensure that a copy of this page only is provided to the patient.

WSIB FAF FORM—APPENDIX E

wsib ONTARIO

Mail to:
200 Front Street West
Toronto ON M5V 3J1

or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Claim No.

A. Section A to be completed by the employer and/or worker.

Worker's Last Name	First Name	Telephone

Address (no., street, apt.)	City/Town	Province	Postal Code

Employer's Name
Full Address (No., Street, Apt.)
City/Town / Prov. / Postal Code

Date of Birth (dd/mm/yyyy)

Date of Accident/ Awareness of Illness (dd/mm/yyyy)

Employer Telephone

Employer Fax No.

fold fold

1. Type of job at time of accident (where available, please attach description of job activities)

Area(s) of injury(ies)/illness(es)

2. Have the worker and the employer discussed Return To Work ☐ yes ☐ no

If no, will be discussed on dd mm yyyy

3. Employer contact name

Position

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature

Date dd mm yyyy

C. Health Professional's Billing Information
For billing purposes fax or mail pages 2 and 3 to the WSIB.

Health Professional's Designation
☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other

PROVIDER BILLING INFORMATION IN THE BOLDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

Are you registered with the WSIB?
☐ yes Please enter the **WSIB Provider ID.** in the box provided
☐ no Please call **1 - 800-569-7919** to register

WSIB Provider ID.

Your Invoice Number

Service Code **FAF**

▼ Complete these fields if **HST** is applicable to this form ▼

HST Registration Number	Service Code	HST Amount Billed
	ONHST	**$** .

Health Professional's Name (please print)

Address (No. Street, Apt.)

City/Town	Province	Postal Code	Fax

I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature	Telephone	Date dd mm yyyy

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wsib ONTARIO

Mail to:
200 Front Street West
Toronto ON M5V 3J1

or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Worker's Last Name	First Name	Claim No.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment dd mm yyyy

2. Please check one:

- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

Travel to work:

Ability to use public transit	Ability to drive a car
☐ yes	☐ yes
☐ no	☐ no

2. Please indicate **Restrictions** that apply. Include additional details in section 3

- ☐ Bending/twisting repetitive movement of (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environmental exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s):

Left		Right
☐	Gripping	☐
☐	Pinching	☐
☐	Other (please specify)	☐

- ☐ Limited pushing/pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify) Do not include names of medications.
- ☐ Exposure to vibration:
  - ☐ Whole body
  - ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions**.

4. From the date of this assessment, the above will apply for approximately:
☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ yes ☐ no

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours

Start Date dd mm yyyy

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions**. dd mm yyyy

I have provided this completed Functional Abilities Form to: ☐ **Worker** **and/or** ☐ **Employer**

Important Information

To receive benefits, the worker must apply for benefits within six months of the date of a work-related injury or illness. When filing a claim for benefits, the worker must also consent to the disclosure of functional abilities information provided by a health professional to his or her employer for the purpose of facilitating an early and safe return to work. Failure to file a claim or provide consent for the release of the functional abilities information can result in no benefits.

If you have questions about the completion of this form please call 1-800-387-0750.

Worker's Responsibilities

- This form is to be completed by a treating health professional, who will discuss the information with you.
- Once completed, contact your employer **immediately** to review the information on the completed form. Together, you and your employer will begin to plan an early and safe return to work.

Employer's Responsibilities

- This form provides general information about this worker's functional abilities and restrictions to help you plan an early and safe return to work.
- When you provide this form to the treating health professional, ensure that you have the worker's signed consent (Section B) for the release of functional abilities information.
- Where available, also attach a description of the worker's job activities to assist the health professional in completing the form.
- The prescribed form that is available from the WSIB is a generic form developed to assist with general functional abilities information.
- The WSIB will pay the health professional to complete the prescribed WSIB form only. A charge will appear on your Accident Cost statement or Schedule 2 Invoice which reflects the cost of payment for each form completed.
- If you have a form that is specific to your workplace and have the cooperation of the worker in providing consent for the release of information on your form, you may use your own form. If you create your own form, you must reimburse the health professional directly.
- Do not send a copy of the completed Functional Abilities Form for Planning Early and Safe Return to Work to the WSIB. The health professional is responsible for submission of the form.

Health Professional's Responsibilities

- The employer and worker will use this information to plan the worker's early and safe return to work.
- Their return to work plans will reflect the functional abilities and restrictions you have noted and presume that no clinical contraindications exist for other work activities, therefore it is crucial that all sections be completed in full.
- The completion of this form is based on your examination of the worker and does not require a specialized functional abilities evaluation.
- Diagnostic or confidential information **must not** be included.
- Please add specific information on the duration of temporary restrictions or maximum times or weights to be considered, in section **E3** under **abilities and/or restrictions**. If necessary, attach an additional page to this completed form to describe abilities and restrictions.
- **Completion of this form does not replace clinical reporting requirements to the WSIB.**
- **Once you have received this form, promptly complete it and give it to the worker and/or employer.**
- **For billing purposes fax or mail pages 2 and 3 to the WSIB. When faxing, do not mail a copy.**

The WSIB will pay the health professional for the completed form when pages 2 and 3 are received.

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

WSIB Fax 416-344-4684
or 1-888-313-7373

revised june 2010

OSSTF/FEESO D/BU–POLICY FOR APPROVAL OF LEGAL ASSISTANCE–APPENDIX F

Workplace Safety & Insurance Board (WSIB) Appeals

1. Before assistance from Provincial Office will be considered, the member and/or the Bargaining Unit Representative should explore the option of asking the WSIB Eligibility Adjudicator (EA) and/or Case Manager (CM) to reconsider the original decision to deny benefits. The Secretariat member assigned to coordinate WSIB appeals should be contacted for advice on reconsideration requests.
2. The member has the responsibility to ensure that the Intent to Object (ITO) time lines, as indicated in the denial letter from WSIB are met. This can be accomplished by completing the ITO form and submitting it to the WSIB.
3. All requests for assistance with WSIB appeals must be forwarded in writing by the Bargaining Unit Representative to the Secretariat member assigned to coordinate WSIB appeals with a copy to the Director of Member Protection and with a copy to the member.
4. Copies of the following documents should be sent in with the request for assistance: WSIB benefit denial letter; documents submitted for a reconsideration (if applicable); and the reconsideration denial letter (if applicable).
5. OSSTF/FEESO must receive authorization to represent the member through the Direction of Authorization (DOA) form.
6. The Secretariat member assigned will send a letter to WSIB informing it of the intent to appeal and request that the member's file be sent to the Provincial Office.
7. The Director of Member Protection may authorize assistance and shall determine the type and level of any assistance provided on the basis of recommendations from the Secretariat member assigned to handle WSIB appeals. The type and level of assistance will be confirmed in writing and all decisions will be final. As a matter of course, members will receive assistance for appeals that have been filed by the employer.

   For member appeals, the decision to grant legal assistance will be made on a case by case basis. A merit review will be conducted as required. The Bargaining Unit and the Field Secretary shall be informed when assistance to a member is authorized.
8. The Secretariat member assigned will act as spokesperson for the member and communicate with WSIB.
9. Assistance will not be provided where the individual was not a member of OSSTF/FEESO at the time the incident(s) giving rise to the complaint took place.

Send the completed and signed form to:
Workplace Safety & Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

OR fax to:
416-344-4684
or
1-888-313-7373

Direction of Authorization - Claims

Claim Nos.
Worker Name
Worker Date of Birth (dd/mm/yy)

For this form to be valid, it must be **completed in full** by the Representative (Parts A and B) and **signed** by the worker or employer (Part D) as applicable.

When submitting by fax, please **transmit** using **only** an **original form**.

Part A - Worker or Employer Directing Authorization

Name ☐ Worker ☐ Employer	Employer/Company Name	
Address	City/Town	Postal Code
Telephone	Fax	Language ☐ English ☐ French ☐ Other (please specify)

Part B - Representative Information

* Name of person and/or organization to be authorized		
Address	City/Town	Postal Code
Telephone	Fax	Signature

Please complete one of the following three (1, 2 or 3) as applicable:

1. My Law Society of Upper Canada or Application ID No.

2. I am / My organization is exempt from the paralegal licensing requirement (please check the exemption that applies to you):

- ☐ In-house legal services provider or paralegal
- ☐ Student legal aid services society
- ☐ Acting for family or friend
- ☐ Office of the Worker Adviser
- ☐ Injured workers' group funded by WSIB
- ☐ Articling student
- ☐ Legal clinic
- ☐ Constituency assistant
- ☐ Office of the Employer Adviser
- ☐ Trade union
- ☐ Other profession or occupation (please specify): _____

If you are unsure about your exemption status, please contact the Law Society of Upper Canada.

3. I am / My organization is excluded from the paralegal licensing requirements (please explain):

* This indicates the person and/or organization who will have authorization as set out on this form. Since October 31, 2007, the WSIB only accepts representatives who have applied for licensing by the Law Society of Upper Canada and whose names are included on the Paralegal Candidate Directory, or those who are exempt or excluded from the licensing requirement. For further information, please consult the Law Society's website at www.lsuc.on.ca. Since October 31, 2007, the WSIB requires all representatives to provide information about their licensing status in order to represent parties before the Board.

Part C - Extent of Authorization and Expiration

The representative named above is authorized to represent the worker or employer in relation to the above noted claim and access all of the WSIB claim-related information that the worker or employer would normally have access to.
This authorization is deemed to be effective for an indefinite period and expires upon receipt of written confirmation by the worker or employer, or upon the death of the worker.

Part D - Approval by Worker or Employer

By signing below, I authorize the person or company named in *Part B* to act as representative, subject to *Part C* noted above.

Name (print)	Position / Title (if applicable)	
Signature		Date (dd/mm/yy)

(Sample letter B)

(Date)

Workplace Safety & Insurance Board
200 Front Street West
Toronto, Ontario
M5V 3J1

Dear WSIB Claim Adjudicator

OSSTF/FEESO represents _____.

Claim No._____

We are objecting to your decision letter dated
At this time, OSSTF/FEESO is requesting that a complete up-to-date copy of the file and an objections form be sent to_____, Executive Assistant responsible for WSIB at the OSSTF/FEESO Provincial Office at 60 Mobile Drive, Toronto, Ontario M4A 2P3.

An authorization form is attached. We would respectfully request a written confirmation of receipt of this letter.

If you have any questions or concerns, please do not hesitate to contact me.

Sincerely

OSSTF/FEESO Bargaining Unit Representative

cc: Injured worker
Executive Assistant responsible for WSIB, OSSTF/FEESO Provincial Office

INITIAL STEPS CHECKLIST—WSIB CLAIMS—APPENDIX G

1. Ensure the employer accident/injury report is completed and submitted.
2. If first aid, healthcare, or lost time from work occurs, assist the member with completing WSIB Form 6 (can be done online at www.WSIB.on.ca).
3. If medical attention is needed, counsel the member to ensure they indicate to the treating health care practitioner that it is a workplace injury and WSIB Form 8 should be completed (can be found online at www.WSIB.on.ca).
4. The employer should complete WSIB Form 7 and they are required by law to give a copy to the member.
5. If the injury has resulted in the need for accommodations, ensure you discuss the local Return to Work (RTW) process with the member and advise them that you will support them at any meetings with the employer in order to protect their rights.
6. If the WSIB is involved if the RTW process, the main health care practitioner will likely need to complete the WSIB Functional Abilities Form (FAF).
7. Advise the member to notify you if they receive any correspondence and/or contact from the WSIB relating to their claim or RTW.
8. If the member's claim is denied, refer to the D/BU in regards to Policy for Approval of Legal Assistance—WSIB appeals section.

HELPFUL HINTS:

- Remind the member to always keep a copy of any document(s) they submit to the employer or the WSIB.
- Counsel the member to keep in communication with you about any changes in status that might affect a RTW plan/proposal.
- Ensure the member only uses the approved forms for WSIB reporting as well as for employer reporting.

SAMPLE LETTER—APPENDIX H

(Sample message to a member from a local leader)

Dear member,

I have just received notification of your workplace injury. I am very sorry to hear of your injury but I am here to help. You are receiving this message so that I may offer assistance and support with any processes or procedures that occur because of your injury such as return to work (RTW) meetings or Workplace Safety and Insurance Board (WSIB) paperwork that may need to be completed.

Thank you for filling in the initial workplace accident report. This is the first step in the process, and a crucial one, if you end up losing time from work and a WSIB claim is to be filed in the future. While the impact of your injury is not fully known at this time, it is critical that reporting is done as soon as possible and health care has been sought if necessary.

Due to your injury, the WSIB may be notified by the employer. You may require some time off work and/or some treatment. You may also need some accommodations/assistance to return to work because of your injury. If any of these scenarios apply to you, you should initiate a WSIB claim by completing the Form 6 and your treating healthcare provider should complete Form 8, both are located at www.WSIB.on.ca.

If your healthcare provider identifies limitations, restrictions or accommodations needed for your return to work, make sure those are documented and we will need to discuss them with the employer at a RTW meeting in advance of you coming back to work. Please make sure that if the employer reaches out to set up RTW meeting that you contact me so that I can ensure you have support in advance and at the meeting to protect your rights. If your state of health and/or needs change at any time during the RTW process, please ensure you keep me informed so that we can discuss changes to the RTW plan with the employer and the WSIB, if they are involved.

If you have any questions, please feel free to reach out to me.

I wish you a speedy recovery and I look forward to supporting you.

In solidarity,

Insert name and title of local leader here

NOTES

Ontario Secondary School Teachers' Federation
Fédération des enseignantes-enseignants des écoles secondaires de l'Ontario
60 Mobile Drive, Toronto, Ontario M4A 2P3

TEL 416.751.8300
TEL 1.800.267.7867
FAX 416.751.3394
www.osstf.on.ca