

COVID-19 initial contact screening questionnaire

Claim number

Name	Date of birth (dd/mmm/yyyy)	
	ating you may have contracted COVID-19 at work. Are you have contracted COVID-19 at work or due to your job?	
Yes No (We will withdraw you	ur claim. Do not complete the remaining questions.)	
	elieve you contracted COVID-19. For example, were you in contact with a person is of COVID-19? How did you contract COVID-19 at work?	
3. Have you experienced any symptoms of COVID-19	9? If so, when did you first start experiencing them?	
Yes Date that symptoms began:		
Describe your symptoms:		
No		
4. Have you been tested for COVID-19?		
Yes. Type of test: Molecular test (PCR o	r rapid molecular testing) Rapid antigen test (work or home-based)	
Date of initial test:	Location of initial test:	
Initial test result: Positive	Negative	
Date of repeat/confirmatory test:	Location of repeat test /confirmatory test:	
Repeat test result: Positive	Negative	
Please submit a copy of your test results with your claim number at wsib.ca/submit.		
No. Reason for not being tested:		
5. Have you seen a doctor or health care professional, received treatment, or been hospitalized for COVID-19? Yes No If yes, indicate whether virtual or in person:		
For each health care provider or hospitalization, please complete the fields below: A. Date of medical visit(s) and/or hospitalization:		
B. Name of provider, address, phone and fax information:		
C. Description of tests, treatment and/or referrals related to COVID-19 diagnosis:		

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.



6. A. What is your j	ob title?	
B. Please descri	be your job duties and work environment (indoors or outdoors, work from home, factory, warehouse, office, etc,)	
7. Have any of you	r household members or close friends who you see often been diagnosed with COVID-19?	
Yes	No	
If yes, did they dev without including na	elop symptoms or were they diagnosed in the two weeks before you developed COVID-19? Please provide details ames:	
	any activities you participate in outside of work, such as sports, going to the gym, social activities or attending nteract with other people:	
	ities that you participate in outside of work, were you exposed to a person or people with confirmed or probable o weeks before you were diagnosed with COVID-19?	
Yes	No	
9. Have you lost tin	ne or wages from work because of COVID-19?	
Yes		
Dates of lost	time:	
Peason for lo	ost time (select all that apply):	
Positive COVID-19 test Self-isolation/quarantine as a precaution		
	9 symptoms	
Other (Pie	ease specify):	
No		
10. Have you return	ned to work?	
Yes. Please p	provide your return-to-work date:	
	s your expected return-to-work date?	
•	u have medical authorization to be off work beyond 10 days from the onset of your symptoms?	
Ye	s No	

Submit forms and documents related to your claim at wsib.ca/submit

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11. Please provide any additional information	11. Please provide any additional information that you think may be relevant to your COVID-19 claim:	
Acknowledgement:		
By checking this box, I,	, acknowledge and agree that:	

The information I have provided is truthful.

I understand that it is an offence to deliberately make false statements to the Workplace Safety and Insurance Board.

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