Did you know that you can report a workplace injury or illness online?

Log in to our online services to report a workplace injury or illness for your employee(s).

Before you start, have the:

- claimant information (name, address, DOB, SIN)
- Injury/illness details
- wage information
- account number
- applicable class/subclass and NAICS code

Please note: submitting a no-lost time claim? Only complete sections A to D, E (#1) and J.

If you are not logging into online services for business, go to PDF version of the form and upload.

Employer's report of injury/disease (Form 7)

WSIB Ontario

7

Claim number

Visit wsib.ca/submit to submit this form and supporting documents.

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		Worker reference number

Last name	First name	Is the worker covered by a Union/Collective Agreement? yes / no
Address (number, street, apt., suite, unit)	City/Town / Province	Worker's preferred language: English / French / Other

Postal code	Telephone	Sex: M / F	Date of birth (dd/mm/yy)	Date of hire (dd/mm/yy)

B. Employer information

Trade and Legal name (if different provide both)	Check one: Firm number / Account number	Provide number
Mailing address	Class/Subclass	NAICS 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 AM PM

Date and hour reported to employer AM PM

2. Who was the accident/illness reported to? (name and position)

Telephone

3. Was the accident/illness:

- Sudden specific event/occurence
- Gradually occurring overtime
- Occupational disease
- Fatality

4. Type of accident/illness: (please check all that apply)

Struck/Caught	Fire/Explosion	Assault
Overexertion	Fall	Slip/Trip
Repetition	Harmful substances/environmental	Motor vehicle incident

Other ....

5. Area of injury (body part) - (Please check all that apply)

Head	Teeth	Upper back
Face	Neck	Lower back
Eye(s)	Chest	Abdomen
Ear(s)		Pelvis

Other: ....

Left		Right	Left		Right	Left		Right	Left		Right
	Shoulder			Wrist			Hip			Ankle	
	Arm			Hand			Thigh			Foot	
	Elbow			Finger(s)			Knee			Toe(s)	
	Forearm						Lower leg				

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 occured gradually over time, please attach a description of the physical activity required to do the work.**

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Claim number

Last name	First 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 recieve health care for this injury? yes no

If yes, when?

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 the accident/awareness of the 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: Myself Other

Name	Telephone	Position

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 Myself Other

Name	Telephone	Position

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Claim number

Last name	First 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				
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	Official title	
Signature	Telephone	Date

Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

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Claim number

Last name	First name	Social Insurance Number

K. Additional information

The Workplace Safety and Insurance Board Act requires you give a copy of this form to your worker