WSIB Ontario | Worker's Progress Report (Form 41)

Claim number

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

Worker's name	Original Date of Accident/Injury	Injury
Accident Employer Name	If any information is incorrect, please provide the changes here	

1. Please check which status best describes your current condition
   - ☐ Recovered ☐ Getting better
   - ☐ No change ☐ Getting worse

Describe any details or changes to your condition:

2. Who is the primary health professional directing your current treatment? Name

Date of last visit (dd/mm/yy)

Date of next visit (dd/mm/yy)

3. Please specify any referrals you have not yet reported to the WSIB

☐ No new referrals ☐ Testing (e.g. labs, x-rays, CT Scan, MRI, etc.) ☐ Specialist ☐ Other (specify)

Name/Facility

Date of that appointment (dd/mm/yy)

4. Are you presently taking any drugs/medications or using an assistive device/brace for this injury? ☐ Yes ☐ No

If **yes**, list names

5. Have you worked for any employer(s) or were you self employed between the first day off and now? ☐ Yes ☐ No

If **yes**, provide details including dates, name/address of employer/company

6. Choose **one** of the following that best describes your **current** situation. **For this claim,**
   - ☐ I **have not** lost any time or pay from work (complete **only** question **7**)
   - ☐ I **have** lost time and/or pay and **have** returned to work (complete **only** questions **7 and 8**)
   - ☐ I **have** lost time and **have not** returned to work (complete **only** questions **9 to 12**)

7. Was your return to work to
   - ☐ a) regular work **OR** ☐ modified work
   - ☐ b) regular pay **OR** ☐ lower pay
   - ☐ c) regular hours **OR** ☐ less hours

8. Date of your return to work (dd/mm/yy)

9. Have you talked to your health professional about return to work? ☐ Yes ☐ No

If **yes**, date of last discussion (dd/mm/yy)

and have they determined your work limitations or functional abilities? ☐ Yes ☐ No

10. Have you talked to your employer about return to work? ☐ Yes ☐ No

If **yes**, date of last discussion (dd/mm/yy)

Name of person you talked to

11. Has any type of work been offered to you? ☐ Yes ☐ No

If **yes**, provide details

12. Are there any other factors that are preventing you from returning to work? ☐ Yes ☐ No

If **yes**, provide details

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 this page is true.

Name	Signature	Date (dd/mm/yy)

☐ 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.

Email accessibility@wsib.on.ca if you need a different format or accommodation. Disponible en français.