WSIB Ontario | **Employer's continuity report (Form WREO7)**

WREO7

Claim number

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

Desk number	Allocation number

Worker's name	Worker's reference number	Original date of accident/injury (dd/mmm/yyyy)
Accident employer name	**Injury**	**Date of recurrence/re-injury (dd/mmm/yyyy)**

1. a) Describe what the worker reports as the cause of this recurrence.

b) Date of reporting (dd/mmm/yyyy)

2. a) Did the worker receive health care for this present recurrence? ☐ Yes ◯ No If **yes**, when? (dd/mmm/yyyy)

b) When did the employer learn that the worker received health care? (dd/mmm/yyyy)

c) Where was the worker treated for this present recurrence?

☐ On-site medical ◯ Emergency department ◯ Health professional office ◯ Clinic ◯ Other

Name/location of health professional/facility

3. Are you aware of any factors or other problems, aside from the original work injury, which may have contributed to this worker's present recurrence? ☐ Yes ◯ No If **yes**, provide details here. **or** ☐ Submission attached

4. From to , has the worker been performing his/her regular work duties? ☐ Yes ◯ No

If **no**, describe the work duties performed.

5. From to , has this worker reported or discussed any ongoing problems with anyone at work about this condition?

If **yes**, names and positions. ☐ Yes ◯ No

6. From to , has the worker sought any medical treatment for this condition? ☐ Yes ◯ No ◯ Unknown

If **yes**, from who?

☐ Chiropractor ◯ Physician ◯ Physiotherapist ◯ Registered nurse (extended class) ◯ Hospital ◯ Other (specify)

7. Between to , did this worker miss any time from work due to this condition? ☐ Yes ◯ No

If **yes**, provide dates.

8. Choose **one** of the following indicators. **As a result of this recurrence/re-injury, this worker:**

☐ Returned to his/her **regular work** and **has not** lost any time and/or earnings. (Complete **only** page **1**)

◯ Returned to **modified work** and **has not** lost any time and/or earnings. (Complete **only** page **1**)

◯ **Has** lost time and/or earnings. (Complete pages **1 and 2**)

→ Date worker first lost time and/or earnings (dd/mmm/yyyy) → Date worker returned to work (if known) (dd/mmm/yyyy) ☐ Regular work ◯ Modified work

9. This Lost Time - No Lost Time - Modified Work information was confirmed by ☐ Myself ◯ Other (Name)	Telephone	Extension

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 and 2 is true.

Name of person completing this report	Official title		
Signature (print, sign and return to the WSIB or type and upload)	**Telephone**	**Extension**	**Date (dd/mmm/yyyy)**

☐ 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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WSIB Ontario | **Post-1998 — Re-open claim earnings (Form WREO7E)**

WREO7E

Claim number

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

Report the worker's earnings at the time of the recurrence.

Worker's name	Original date of accident/injury **(DOA)** (dd/mmm/yyyy)	Date of recurrence/re-injury (dd/mmm/yyyy)

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

2. Net claim code or amount
Federal _____ Provincial _____

3. Vacation pay on each cheque? ◯ Yes ◯ No
Provide percentage _____ %

4. Actual working hours on last day worked
From _____ ☐ AM ◯ PM
To ☐ AM ◯ PM

5. Normal working hours for last day worked
From _____ ☐ AM ◯ PM
To ☐ AM ◯ PM

6. Actual earnings on last day worked
$ _____

7. Normal earnings for last day worked
$ _____

8. Advances on wages - Is the worker being paid while he/she recovers? ◯ Yes ◯ No

If yes, indicate:
◯ Full/regular ◯ Other ➡ Paid by ◯ Employer ◯ Third party/ insurance plan

If by a third party/insurance plan, provide:
Name | Phone

9. Other earnings (not regular wages): Provide the **total of additional earnings** for each week for the 4 weeks before the recurrence/re-injury.

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 recurrence/re-injury.

Use these spaces for any other earnings (indicate differentials, premiums, tips, 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			$	$	$	$	$	$

Regular production bonuses/commission:

If paid weekly Did this worker receive payment in each of the 4 weeks before the layoff? ☐ Yes ◯ No If yes, what is the average gross weekly amount? $ _____

If paid monthly Did this worker receive payment in each of the 3 months before the layoff? ☐ Yes ◯ No If yes, what is the average gross monthly amount? $ _____

Is worker receiving any payments in lieu of benefits? ☐ Yes ◯ No If yes, what is the percentage? _____ %

10. Work schedule (complete either A or 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

S	M	T	W	T	F	S
	8	8	8	8	8	

(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.

(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 recurrence/re-injury. (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				

Name	Signature (print, sign and return to the WSIB or type and upload)	Date (dd/mmm/yyyy)

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