Voluntary x-ray and pulmonary function test submission form

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

Company number	Social insurance number	Examination date (dd/mm/yyyy)	Film number	Ontario Regulation Film Services (ORFS) number

Company name	Division of

Employee's last name	First name	Middle initial

First year of exposure (yyyy)	Date of birth (dd/mm/yyyy)	Miner's number	Birthplace

Employee's home address	Postal code

Employment history

From (dd/mm/yy)	To (dd/mm/yy)	Employer	Work location	Occupation	Mining industry M S UG OP	Type of ore

Mining industry: **M – Milling** **S – Surface mining** **UG – Underground mining** **OP – Open pit mining**

Test and release authorization

As the examining physician for the above-named employee under the Occupational Health and Safety Act (OHSA) R.S.O. 1990, c.O.1, s. 12(3), I acknowledge that I have reviewed the above-named person's x-ray and pulmonary function test, if applicable, and no longer require it for clinical purposes. I do not have the capacity to store the x-ray and/or pulmonary function test in my practice and am therefore requesting it be sent to the WSIB for storage purposes c/o the following address:

Workplace Safety and Insurance Board
Ontario Regulation Film Services (ORFS) Program
200 Front St. W, 14th floor
Toronto ON M5V 3J1

I understand that the WSIB will not review the x-ray or pulmonary function test unless at a future date a claim is filed for the above-named person.

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

Personal information collection

The personal information contained in this form is collected under the OHSA R.S.O. 1990, c.O.1, s. 12(3) for the registration of workers associated with the designated substance regulations for asbestos and silica. For information concerning the collection of this information, please call us at 1-800-387-0750 or locally at 416-344-1000. TTY: 1-800-387-0050.

Physician's name	Signature

☐ No x-ray ☐ No pulmonary function test

Clinic address	Suite number	City	Province

Telephone number	Date (dd/mm/yyyy)	College of Physicians and Surgeons of Ontario registration number

Employee's statement

I agree that the results of the tests outlined by the above physician be sent to and stored at the WSIB. I consent to release these records to the WSIB in the event a claim is filed in the future, as this information would be required to help make a decision about the claim.

Employee's signature	Telephone number	Date (dd/mm/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.