

## WSIB Fact Reporting Form

Worker's Name: \_\_\_\_\_ Claim#: \_\_\_\_\_

Accident Date: \_\_\_\_\_

Worker's Address: \_\_\_\_\_

Street name and number City Postal Code

Telephone # Home: \_\_\_\_\_ Work: \_\_\_\_\_

Name of your Union  
Representative: \_\_\_\_\_

District Name & #: \_\_\_\_\_ Bargaining Unit: \_\_\_\_\_

Workplace Location: \_\_\_\_\_

Birth Date: \_\_\_\_\_  
Day Month Year

Family Doctor: \_\_\_\_\_

Address: \_\_\_\_\_  
Street name and number City Postal Code

Specialist: \_\_\_\_\_

Address: \_\_\_\_\_  
Street name and number City Postal Code

Description of  
Accident/Incident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Witnesses: \_\_\_\_\_

Return to Work Approved by Physician? Yes  No

Restrictions? Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_