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.

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

7

Claim number

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	Worker's preferred language ☐ English ☐ French ☐ Other .....

Province	Postal code	Telephone	Date of birth (dd/mm/yy)	Sex ☐ Male ☐ Female	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
- ☐ Face
- ☐ Eye(s)
- ☐ Ear(s)
- ☐ Teeth
- ☐ Neck
- ☐ Chest
- ☐ Upper back
- ☐ Lower back
- ☐ Abdomen
- ☐ 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.**

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

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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 ☐ Casual/Irregular ☐ Student ☐ Registered apprentice ☐ Owner operator or (sub) contractor
☐ Permanent part time ☐ Seasonal ☐ Unpaid/Trainee ☐ Optional insurance
☐ Temporary full time ☐ Contract
☐ Temporary part time ☐ Other .....

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.

Period	From date (dd/mm/yy)	To date (dd/mm/yy)	Mandatory overtime pay	Voluntary overtime pay	Use these spaces for any other earnings (indicate Commission, Differentials, Premiums, Bonus, Tips, In Lieu %, etc.). -Choose one-	-Choose one-	-Choose one-	-Choose one-
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 (please print)	Official title	
Signature (print, sign and return to the WSIB or type and upload)	Telephone	Date

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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

Upload form and supporting documents online at wsib.ca/upload.