wsib ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail To:
200 Front Street West
Toronto ON M5V 3J1

OR Fax To:
416-344-4684
OR 1-888-313-7373

41 Worker's Progress Report (Form 41)

Claim Number

Please PRINT in black ink

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.

Signature	Date dd/mm/yy