ON Employee Injury/Accident Report Form

Instructions for Injured Employees (or Designate) and Their Supervisors

NOTE: Personal information collected on this form is collected for the purposes of generating injury related statistics for the employer and in accordance with the Workplace Safety and Insurance Act, 1997, the submission of a worker's claim for compensation

	Employee				
Step 1	Complete the Employee Injury/Accident Report Form	➔	Sign and Fax the completed form to the Disability Management Institute (DMI)	➔	Fax Number 705-797-5149
Step 2	Submit the completed form to your employer	➔	If you have questions call DMI	➔	Toll Free Phone Number 1-866-459-3066

If you require additional space for comments, please attach a separate sheet of paper and submit with the Employee Injury/Accident Report Form

SECTION A: EMPLOYEE'S REPORT

Please Print

Site / Location			Employer:
Last Name		First Name	Phone
Address (No, St, Apt)		City/Town	Postal Code
Birth Date (M/D/Y)		Date of Employment	Interpreter Required Yes ☐ No ☐ Language:
Work Phone & Local		SIN	Position/Occupation
Injury Date (M/D/Y)	Time	Date/Time Reported	Reported to

Describe How and Where the Incident/Accident Happened

Describe (in detail) Your Injured Body Part (incl. right or left)

Were you injured?	Did/will you seek first aid?	Did/will you see a doctor?	Doctor/Clinic Name	Did/will you go to Emergency?
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

Did you/will you lose time from work beyond the date of injury? Yes ☐ No ☐

Name of Witness: Name of Supervisor:

MY EMPLOYER HAS ADVISED ME THAT MODIFIED WORK IS AVAILBLE. Yes ☐ No ☐

Personal information about you will be collected throughout your claim under the authority of the Freedom of Information and Protection of Privacy Act and will be used to administer the Workplace Safety and Insurance Act, 1997, your claim and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, and others as required. Your social insurance number is used to register claims, identify workers and to issue income tax receipts and is collected under the authority of the Income Tax Act. Information may only be disclosed to the employer, external medical, vocational, and safety agencies, external payment and service providers, researchers, and others as authorized by the Workplace Safety and Insurance Act and the freedom of Information and Protection of Privacy Act. Your name and telephone number may be disclosed to third party researchers conducting satisfaction surveys and focus groups. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.

Signature of Injured Employee: Date ________________________Month/Day Year

FAX THE COMPLETE FORM TO DMI AT 705-797-5149