

EARLY INTERVENTION NOTIFICATION FORM

Complete this form anytime an employee has been, or will be absent from work for 5 consecutive shifts due to illness or injury.

Send the form to DMI via toll-free fax or email.
Any questions? Please call DMI 1-866-963-9995

Fax: 604-542-3850 | 1-866-963-9994
OR
Email: eip@mydmi.ca

EMPLOYEE CONTACT INFORMATION

Employer		Site / Location	
Last Name	First Name	Preferred Name	
Date of Birth (day/month/year)	Pronoun <input type="checkbox"/> She/her <input type="checkbox"/> He/him <input type="checkbox"/> They/them <input type="checkbox"/> Xe/Xem <input type="checkbox"/> Ze/Zir <input type="checkbox"/> Other _____		

Address		City
Province	Postal Code	
Phone Home #	Mobile Phone #	
Email Address	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French	

Is the employee a union member? <input type="checkbox"/> Yes, Union Name _____ <input type="checkbox"/> No								
Job Title						Average hours/week: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		
Indicate Daily Schedule	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	<input type="checkbox"/> Fixed Weekly Schedule <input type="checkbox"/> Variable Rotating Schedule <input type="checkbox"/> Fixed Rotating Schedule <input type="checkbox"/> Casual Employee
Last Day Worked: (DD/MM/YYYY)		Date First Absent: (DD/MM/YYYY)		Expected Return to Work Date: (DD/MM/YYYY)			Date Faxed to DMI: (DD/MM/YYYY)	

Absence related to a workplace injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when did the accident occur? (DD/MM/YYYY)
Was there an WCB Claim Filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify WCB Number:

EMPLOYER CONTACT INFORMATION

Employer Contact Name			
Employer Contact Phone		Employer Contact Email Address	
Is the employee currently hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Is there any additional information about this absence that DMI should be aware of, prior to contacting the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list any additional employer contacts that should be updated in relation to this claim:

Name(s): _____	Email Address(es): _____
_____	_____
_____	_____
_____	_____

PLEASE SEND THIS COMPLETED FORM TO DMI WITH DOCTOR'S NOTE (IF PROVIDED) TOLL FREE FAX: 1-866-963-9994