

Early Intervention Contact Sheet Instructions for the Employer



Western Canada Region
(BC)

Phone 1-866-963-9995 or 604-542-3649

Eastern Canada Region

(AB, SK, MB, ON, QC, & Eastern Provinces)
Phone 1-866-459-3066

EMPLOYEE CONTACT INFORMATION								Please Print	
Employer:			Site / Location:			English: <input type="checkbox"/>			
						French: <input type="checkbox"/>			
Last Name:		First Name:			Home Phone:				
Address:			Postal Code:		Alternate / Cell Phone:				
Date of Birth:		Email Address:		Union: <input type="checkbox"/> NO <input type="checkbox"/> YES		Union Name:			
Job Title:			Average hours/ week:		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time				
Indicate Daily Schedule	Sun	Mon	Tue	Wed	Thu	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"/> NO <input type="checkbox"/> YES	Date of Incident: (DD/MM/YYYY)	WCB claim filed?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Specify WCB Claim Number:
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EMPLOYER CONTACT INFORMATION			Please Print
Employer Contact Name	Employer Contact Phone	Employer Contact Email Address	
Is the employee currently hospitalized? <input type="checkbox"/> NO <input type="checkbox"/> YES <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"/> NO <input type="checkbox"/> YES	
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			