Report of Injury Form

Employee		Employer/Supervisor		
Seek first aid if required. Report injury to your manager/supervisor	➔	If needed, arrange for medical attention. Complete this form with the employee and send to Disability Management Institute (DMI) only if employee misses time from work and/or receives medical attention ➔If you have questions call DMI toll free 1-866-963-9995	➔	Fax Number 1-888-994-9047 wcbclaims@disabilityinstitute.com

SECTION A: EMPLOYEE INFORMATION

Last Name:	First Name:	Employee's Phone:
Employer:		Site / Location:
Employee's Address (No, St, Apt):	City/Town:	Postal Code:
Birth Date (MM/DD/YYYY):	SIN:	Position/Occupation:
Work Phone & Local:	Name/Phone # of Supervisor:	

SECTION B: ACCIDENT DETAILS

Injury Date and Time:			Reported to:
Witnesses:			Reported Date and Time :
Type of Accident (check one):	❑ First Aid Only	❑ Medical Treatment	❑ Lost Time
Description of the Incident:			Where did the Incident Occur:
Body Part(s) Injured:			
Lost Time accident only if time was missed ***beyond*** date of injury	Date Last Worked:		Date of First Shift Missed:

SECTION C: MEDICAL TREATMENT

Did employee obtain First Aid:	❑ Yes ❑ No	Date and Time :	Name of First Aid Attendant:
Did employee seek medical attention:	❑ Yes ❑ No		If YES, indicate Date:
Date employer notified of medical treatment:			

SECTION D: SCHEDULE AND EARNINGS INFORMATION

Employment Status (check all that apply):

☐ Permanent Full Time
☐ Permanent Part Time
☐ Temporary Full Time
☐ Temporary Part Time
☐ Casual/Irregular
☐ Seasonal
☐ Contract
☐ Student
☐ Registered Apprentice
☐ Other: _____

Regular rate of pay $ _____ ☐ Hour ☐ Other:

If worker has a fixed schedule, please identify days and hours worked:

Week 1

Sun	Mon	Tue	Wed	Thu	Fri	Sat

Week 2

Sun	Mon	Tue	Wed	Thu	Fri	Sat

If not a full time employee, please identify average hours worked per week: _____

SECTION E: RETURN TO WORK (RTW)

Has the employee returned to work? ❑ Yes ❑ No

If YES, indicate date: _____ To: ❑ Regular Duties ❑ Modified Duties

If NO, has the employee been provided with a ***written*** modified work offer? ❑ Yes ❑ No

If YES to modified duties, please attach a copy of the modified work offer: ❑ Attached

I declare all the information I have given on this report is true and correct. I understand that by completing this form, the Disability Management Institute will submit a "Form 7" in accordance with Worker's Compensation Act and the Occupational Health and Safety Regulations and as such, I elect to claim compensation for the above mentioned injury(s) or disease(s), where said injury or disease has resulted in medical costs or lost time from work. I acknowledge that the WCB may disclose information from my claim to my employer or my employer's authorized agent for the purposes of the management of my claim in accordance with the law including the *Freedom of information and Privacy Act* and *the Personal Information Privacy Act*. I understand it is a serious offense to knowingly make a false claim or to work and earn income while receiving compensation without advising the WCB

Signature of Injured Employee: **Date:**

Supervisor/Employer Contact: **Signature:** **Date:**

Do you have any concerns or relevant information regarding this claim you wish to discuss with DMI? ❑ Yes ❑ No

Comments: