WSIB Accident Information and Agreement Form

Patient Name_____ WSIB Claim #_____
Social Insurance #_____
Employer Name _____ Phone _____
Name of Supervisor/Manager _____Fax# _____
Address _____ Postal_____
Your Occupation _____ Date of Injury _____
Did you report this injury? _____ To whom? _____ Date _____
How long have you worked there? ___years ___months Today's Date_____

INCIDENT DETAILS

Give a detailed description of what happened and how you were injured:

_____
_____

Please give details about any physical conditions that may have contributed to your injury, ie: wet floor, dark, improper equipment, etc

_____

Were you seen/treated by a health professional immediately following your injury? _____ If yes, Who_____ When? Date _____

Have you missed any work? __ If yes, please list dates & times _____

Check all that apply: ___ No Limitations ___ Bending/Twisting ___Climbing
___ Kneeling ___ Lifting ___Medication ___Operating Heavy Equipment
___ Operation of Motor Vehicle ___Personal Protective Equipment __Sitting
___ Standing __Use of Public Transportation ___Pushing/Pulling ___ Walking
___ Use of Upper Extremities __Other _____

Does your employer have modified work for you? __ Yes __ No or Graduated Hours? __Yes __No

AGREEMENT

WSIB will automatically pay for your Initial Examination. Then a determination is made by WSIB to approve or deny chiropractic treatment. Therefore you are responsible for paying for your treatment if your case is denied.

Signed _____

Date _____

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