Transmission Report

Date/Time	11-25-2019	18:15:19	Transmit Header Text		
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Document size : 8.5"x11"

1 of 4

wsib cspaat ONTARIO

Mail To: 200 Front Street West Toronto ON M5V 3J1
OR Fax To: 416-344-4684 OR 1-888-313-7373

Please PRINT in black ink

7 Employer's Report of Injury/Disease (Form 7)

Claim Number

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations): Accounts Payable/Finance Clerk

Length of time in this position while working for you: 2.5 years

Social Insurance Number: 4 9 2 0 0 3 7 4 4

Please check if this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name: Cheechoo
First Name: Joanne
Address (number, street, apt., suite, unit): 725 Mountain Road
City/Town: Thunder Bay
Province: ON
Postal Code: P7J 1C1

Is the worker covered by a Union/Collective Agreement? ☐ yes ■ no

Worker Reference Number:

Worker's preferred language: ■ English ☐ French ☐ Other

Date of Birth: dd 25 mm 03 yy 73

Telephone:

Sex: ☐ M ■ F

Date of Hire: dd 13 mm 02 yy 17

Fold here for #10 envelope

B. Employer Information

Trade and Legal Name (if different provide both): Nishnawbe-Aski Legal Services Corporation

Check one: ☐ Firm Number OR ■ Account Number — Provide Number:

Mailing Address: 1805 Arthur St. East

Rate Group Number:

Classification Unit Code:

City/Town: Thunder Bay
Province: ON
Postal Code:
Telephone: 807-622-1413

Description of Business Activity: Legal Services

Does your firm have 20 or more workers? ■ yes ☐ no

FAX Number:

Branch Address where worker is based (if different from mailing address - no abbreviations)

City/Town:
Province:
Postal Code:
Alternate Telephone:

C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness: dd 19 mm 11 yy 19 ☐ AM ☐ PM

Date and hour reported to employer: dd 21 mm 11 yy 19 9:00 ■ AM ☐ PM

2. Who was the accident/illness reported to? (Name & Position): Colette Shwetz, HR

Telephone: 807-622-1413 Ext. 7714

3. Was the accident/illness:
■ Sudden Specific Event/Occurrence
☐ Gradually Occurring Over Time
☐ Occupational Disease
☐ Fatality

4. Type of accident/illness: **(Please check all that apply)**
☐ Struck/Caught
☐ Overexertion
☐ Repetition
☐ Fire/Explosion
■ Fall
☐ Harmful Substances/Environmental
☐ Assault
☐ Other
☐ Slip/Trip
☐ Motor Vehicle Incident

5. Area of Injury (Body Part) - **(Please check all that apply)**
☐ Head ☐ Face ☐ Eye(s) ☐ Ear(s) ☐ Other
☐ Teeth ☐ Neck ☐ Chest
☐ Upper back ☐ Lower back ☐ Abdomen ☐ Pelvis
Left ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm — Right ☐
Left ☐ Wrist ☐ Hand ☐ Finger(s) — Right ■
Left ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg — Right ☐
Left ☐ Ankle ☐ Foot ☐ Toe(s) — Right ☐

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc. . .). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

On Tuesday, i was about to sit down on my chair and my right foot stepped on the wheels which than I tried to brace my fall by catching the arm of my chair. My thumb was aching yesterday but today I cannot bed or hold any objects.

0007A (01/11) **A guide to complete this form is available at www.wsib.on.ca** Page 1 of 4

Total Pages Scanned : 4 Total Pages Confirmed : 4

No.	Job	Remote Station	Start Time	Duration	Pages	Line	Mode	Job Type	Results
001	947	WSIB	18:11:42 11-25-2019	00:03:17	4/4	1	G3	HS	CP14400

Abbreviations:

HS: Host send	PL: Polled local	MP: Mailbox print	CP: Completed	TS: Terminated by system
HR: Host receive	PR: Polled remote	RP: Report	FA: Fail	G3: Group 3
WS: Waiting send	MS: Mailbox save	FF: Fax Forward	TU: Terminated by user	EC: Error Correct

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Please check **if** this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name: **Cheechoo**

First Name: **Joanne**

Address (number, street, apt., suite, unit): **725 Mountain Road**

City/Town: **Thunder Bay**

Province: **ON**

Postal Code: **P7J 1C1**

Is the worker covered by a Union/Collective Agreement? ☐ yes ☒ no

Worker Reference Number:

Worker's preferred language ☒ English ☐ French ☐ Other

Date of Birth (dd mm yy): **25 03 73**

Telephone:

Sex ☐ M ☒ F

Date of Hire (dd mm yy): **13 02 17**

Fold here for #10 envelope

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City/Town: **Thunder Bay**

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Description of Business Activity: **Legal Services**

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C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness (dd mm yy): **19 11 19** ☐ AM ☐ PM

Date and hour reported to employer (dd mm yy): **21 11 19** 9:00 ☒ AM ☐ PM

2. Who was the accident/illness reported to? (Name & Position): **Colette Shwetz, HR**

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Left ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm — Right ☐
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Left ☐ Ankle ☐ Foot ☐ Toe(s) — Right ☐
☐ Other

6. Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc. . .). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

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7 Employer's Report of Injury/Disease (Form 7)

Please PRINT in black ink

Claim Number

Worker Name		Social Insurance Number
Cheechoo	Joanne	492003744

C. Accident/Illness Dates and Details (Continued)

7. Did the accident/illness happen on the employer's premises (owned, leased or maintained)? ■ yes ☐ no
Specify where (shop floor, warehouse, client/customer site, parking lot, etc..): At the finance office

8. Did the accident/illness happen outside the Province of Ontario? ☐ yes ■ no
If **yes,** where (city, province/state, country).

9. Are you aware of any witnesses or other employees involved in this accident/illness? ■ yes ☐ no
If **yes,** provide name(s), position(s), and work phone number(s).
1. Tara Thompson, Finance Controller
2.

10. Was any individual, who does not work for your firm, partially or totally responsible for this accident/illness? ☐ yes ■ no
If **yes,** please provide name and work phone number

11. Are you aware of any prior similar or related problem, injury or condition? ☐ yes ■ no
If **yes,** please explain

12. If you have concerns about this claim, attach a written submission to this form. ☐ submission attached

D. Health Care

1. Did the worker receive health care for this injury? ■ yes ☐ no
If **yes,** when : dd mm yy

2. When did the employer learn that the worker received health care? dd mm yy: 21119

3. Where was the worker treated for this injury? **(Please check all that apply)**
☐ On-site health care ☐ Ambulance ■ Emergency department ☐ Admitted to hospital ☐ Health professional office ☐ Clinic
☐ Other:

Name, address and phone number of health professional or facility who treated this worker (if known): Emergency Dept. at the Thunder Bay Regional Health Sciences Center, 980 Oliver Rd., Thunder Bay, ON

E. Lost Time - No Lost Time

1. Please choose one of the following indicators. **After the day of accident/awareness of illness, this worker:**
☐ Returned to his/her **regular job** and **has not** lost any time and/or earnings. **(Complete sections G and J).**
■ Returned to **modified work** and **has not** lost any time and/or earnings. **(Complete sections F, G, and J).**
☐ **Has** lost time and/or earnings. **(Complete ALL remaining sections).**

Provide date worker first lost time: dd mm yy
Date worker returned to work (if known): dd mm yy: 21119 ☐ regular work ■ modified work

2. This Lost Time - No Lost Time - Modified Work information was confirmed by: Telephone Ext.
■ Myself ☐ Other
Name

F. Return To Work

1. Have you been provided with work limitations for this worker's injury? ■ yes ☐ no

2. Has modified work been discussed with this worker? ■ yes ☐ no

3. Has modified work been offered to this worker? ■ yes ☐ no
If **yes,** was it ■ Accepted ☐ Declined
☐ If Declined please attach a copy of the written offer given to the worker.

4. Who is responsible for arranging worker's return to work Telephone Ext.
■ Myself ☐ Other
Name

3 of 4

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7 Employer's Report of Injury/Disease (Form 7)

Claim Number

Please PRINT in black ink

Worker Name		Social Insurance Number
Cheechoo	Joanne	492003744

G. Base Wage/Employment Information - (Do not include overtime here)

1. Is this worker **(Please check all that apply)**

- [x] Permanent Full Time
- [ ] Permanent Part Time
- [ ] Temporary Full Time
- [ ] Temporary Part Time
- [ ] Casual/Irregular
- [ ] Seasonal
- [ ] Contract
- [ ] Student
- [ ] Unpaid/Trainee
- [ ] Other
- [ ] Registered Apprentice
- [ ] Optional Insurance
- [ ] Owner Operator or (Sub) Contractor

2. Regular rate of pay $ 28.57 per [x] hour [ ] day [ ] week [ ] other

H. Additional Wage Information

1. Net Claim Code or Amount — Federal: ____ Provincial: ____

2. Vacation pay - on each cheque? [ ] yes [ ] no — Provide percentage ____ %

3. Date and hour last worked — dd mm yy — [ ] AM [ ] PM

4. Normal working hours on last day worked — From [ ] AM [ ] PM To [ ] AM [ ] PM

5. Actual earnings for last day worked — $ ____

6. Normal earnings for last day worked — $ ____

7. Advances on wages: Is the worker being paid while he/she recovers? [ ] yes [ ] no If yes, indicate: [ ] Full/Regular [ ] Other ____

8. Other Earnings (Not Regular Wages): Provide the **total of additional earnings** for each week for the 4 weeks before the accident/illness.

* For Rotational Shift workers - If the shift cycle exceeds 4 weeks, please attach the earnings information for the last complete shift cycle prior to the date of accident/illness.

▼ Use these spaces for any other earnings (indicate Commission, Differentials, Premiums, Bonus, Tips, In Lieu %, etc..).

Period	From Date (dd/mm/yy)	To Date (dd/mm/yy)	Mandatory Overtime Pay	Voluntary Overtime Pay	Commission	Commission	Commission	Commission
Week 1			$	$	$	$	$	$
Week 2			$	$	$	$	$	$
Week 3			$	$	$	$	$	$
Week 4			$	$	$	$	$	$

I. Work Schedule (Complete either **A, B or C. Do not** include overtime shifts)

[ ] **(A.) Regular Schedule** - Indicate normal work days and hours.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

▶ **Example:** Monday to Friday, 40 hours

S	M	T	W	T	F	S
	8	8	8	8	8	

or,

[ ] **(B.) Repeating Rotational Shift Worker** - Provide

NUMBER OF DAYS ON	NUMBER OF DAYS OFF	HOURS PER SHIFT(s)	NUMBER OF WEEKS IN CYCLE

▶ **Example:** 4 days on, 4 days off, 12 hours per shift, 8 weeks in cycle.

or,

[ ] **(C.) Varied or Irregular Work Schedule** - Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the accident/illness. (Do not include overtime hours or shifts here).

	Week 1	Week 2	Week 3	Week 4
From/To Dates (dd/mm/yy)	/	/	/	/
Total Hours Worked				
Total Shifts Worked				

J. It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I declare that all of the information provided on pages 1, 2, and 3 is true.

Name of person completing this report (please print): Colette Shwetz

Official title: H.R. Manager

Signature: Colette Shwetz

Telephone: 807-622-1413 Ext. 114

Date: 25 / 11 / 19

THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER

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7 Employer's Report of Injury/Disease (Form 7)

Claim Number

Please PRINT in black ink

Worker Name		Social Insurance Number
Cheechoo	Joanne	492003744

K. Additional Information

THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER

wsib cspaat ONTARIO

Claim Number (If known)

8 Health Professional's Report (Form 8)

Return To Work Information

Once completed, please ensure that a copy of this page only is provided to the worker.

Last Name	First Name	Init.	Birth Date (dd mm yyyy)
Cheechoo	Joanne	J	25 03 1973

Area(s) of Injury(ies)/Illness(es): Rt Thumb Injury

Date of Incident (dd mm yyyy): 19 11 2019

F. Return To Work Information - Must be completed by a Health Professional

When work injury/illness occurs, focus on return to usual activity including return to safe and appropriate work is best practice. Most workers who experience soft tissue injury are able to remain at work.

1. Have you discussed return to work with your patient? ☒ yes ☐ no

2. ☐ **This worker can resume Regular duties. Start date** (dd mm yyyy) **If graduated hours required please specify**

☒ **This worker can begin Modified duties. Start date** 21 11 2019 **If graduated hours required please specify**

☐ **This worker is not able to work because of the workplace injury/illness.**

Please provide explanation

3. Please indicate the worker's status and functional abilities in relation to the workplace injury and diagnosis.

A. Full Functional Abilities ☐

B. Worker Functional Abilities

	Able to	Not Able to
Bend/Twist	☒	☐
Climb	☒	☐
Kneel	☒	☐
Lift	☐	☒
Operate Heavy Equipment	☐	☒
Operate a Motor Vehicle	☒	☐
Push/Pull	☐	☒
Sit	☐	☒
Stand	☒	☐
Use of Public Transportation	☒	☐
Use of Upper Extremities	☐	☒
Walk	☒	☐

C. Other Limitations: eg. Environmental Conditions, Medication, Use of Protective Equipment.

Please describe: Pain of (R) hand for writing, or lifting, may type of hand or tolerated

4. From the date of this assessment, the above limitations will apply for approximately:

1 - 2 days ☒ 3 - 7 days 8 - 14 days 14 + days

5. Follow-up Appointment

☐ None required ☒ As Needed Date of next appointment (dd mm yyyy)

Health Professional's Name (Please print)	Address
Evelyn	980 Oliver Rd
Health Professional's Signature	**Telephone** 807-6846100
	Service Date (dd mm yyyy) 21 11 2019

G. Worker's Signature

By signing below I am authorizing the above noted health professional, who is treating me, to provide my employer with a copy of this page outlining my functional abilities. I understand a copy will be sent to the Workplace Safety and Insurance Board (WSIB) by my health professional.

Signature	Date (dd mm yyyy)
Joanne Cheechoo	21 11 2019

Once completed, please ensure that a copy of this page only is provided to the worker.