wsib ONTARIO

# Employer's report of injury/disease (Form 7)

**Submit this form and supporting documents at wsib.ca/submit**

**7** Claim number

## A. Worker information

| Job title/Occupation (at the time of accident/illness - do not use abbreviations) | Length of time in this position while working for you | Social insurance number |
|---|---|---|
| **Finance Manager** | **2 Years** | **492 003 744** |

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

Worker reference number:

| Last name | First name | Is the worker covered by a Union/Collective Agreement? |
|---|---|---|
| **Cheechoo** | **Joanne** | ☐ yes ☒ no |

| Address (number, street, apt., suite, unit) | City/Town | Province | Worker's preferred language |
|---|---|---|---|
| **725 Mountain Road** | **Thunder Bay** | **ON** | ☒ English ☐ French ☐ Other |

| Postal code | Telephone | Sex | Date of birth (dd/mm/yy) | Date of hire (dd/mm/yy) |
|---|---|---|---|---|
| **P7J 1C1** | **(807) 630-0580** | ☐ M ☒ F | **25/03/1972** | **22/03/2022** |

## B. Employer information

| Trade and Legal name (if different provide both) | Check one: | Provide number |
|---|---|---|
| **Nishnawbe-Aski Legal Services Corporation** | ☐ Firm number ☒ Account number | **642085** |

| Mailing address | Class/Subclass | NAICS Code |
|---|---|---|
| **101 Syndicate North, Suite 101** | | **541110** |

| City/Town | Province | Postal code | Telephone |
|---|---|---|---|
| **Thunder Bay** | **ON** | **P7C 3V4** | **(807) 622-1413** |

| Description of business activity | Does your firm have 20 or more workers? | Fax number |
|---|---|---|
| **Legal Services** | ☒ yes ☐ no | **(807) 622-3024** |

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

| | | | |
|---|---|---|---|
| **678 City Road** | | | |
| City/Town | Province | Postal code | Alternate telephone |
| **Fort William First Nation** | **ON** | **P7J 1K3** | |

## C. Accident/illness dates and details

1. Date and hour of accident/Awareness of illness
**Sept 9th, 2024** **10** ☒ AM ☐ PM

Date and hour reported to employer
**Sept 25th, 2024** **4** ☐ AM ☒ PM

2. Who was the accident/illness reported to? (name and position)
**Liberty Gorman**
**Recruitment Coordinator**

Telephone: **(807) 633-1695**

3. Was the accident/illness:
- ☒ Sudden specific event/occurence
- ☐ Gradually occurring overtime
- ☐ Occupational disease
- ☐ Fatality

4. Type of accident/illness: (please check all that apply)
- ☑ Struck/Caught
- ☐ Overexertion
- ☐ Repetition
- ☐ Fire/Explosion
- ☐ Fall
- ☐ Harmful substances/environmental
- ☐ Other
- ☐ Assault
- ☐ Slip/Trip
- ☐ Motor vehicle incident

5. Area of injury (body part) - (Please check all that apply)

| | | | Left | | Right | Left | | Right | Left | | Right | Left | | Right |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ Head | ☐ Teeth | ☐ Upper back | ☐ | Shoulder | ☐ | ☐ | Wrist | ☐ | ☐ | Hip | ☐ | ☐ | Ankle | ☐ |
| ☐ Face | ☐ Neck | ☐ Lower back | ☐ | Arm | ☐ | ☑ | Hand | ☐ | ☐ | Thigh | ☐ | ☐ | Foot | ☐ |
| ☐ Eye(s) | ☐ Chest | ☐ Abdomen | ☐ | Elbow | ☐ | ☐ | Finger(s) | ☐ | ☐ | Knee | ☐ | ☐ | Toe(s) | ☐ |
| ☐ Ear(s) | | ☐ Pelvis | ☐ | Forearm | ☐ | | | | ☐ | Lower leg | ☐ | | | |
| ☐ 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 occured gradually over time, please attach a description of the physical activity required to do the work.**

**Worker was moving new furniture. As she pulled a table her left hand slipped and hit the corner of her desk. She put a cold compress on it a couple hours alter and her hand swelled for a short period. In her incident report she noted the pain has not subsided since and she has been wearing a hand brace. Pain on her pinky and ring finger.**

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

Ce document est disponible en français sous le titre : *Avis de lésion ou de maladie (employeur)*, 0007B (03/24)

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Claim number

| Last name | First name | Social Insurance Number |
|---|---|---|
| Cheechoo | Joanne | 492 003 744 |

**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.). **Worker's 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.

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 recieve health care for this injury? ☐ yes ☑ no
   If yes, when?

2. When did the employer learn that the worker received health care? (dd/mm/yy)

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)

**E. Lost time - no lost time**

1. Please choose one of the following indicators. After the day of the accident/awareness of the 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) | ☐ Regular work ☐ Modified work |
|---|---|---|
| | | |

2. This lost time - no lost time - Modified work information was confirmed by: ☐ Myself ☐ Other

| Name | Telephone | Position |
|---|---|---|
| | | |

**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 ☐ Myself ☐ Other

| Name | Telephone | Position |
|---|---|---|
| | | |

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Claim number

| Last name | First name | Social Insurance Number |
|---|---|---|
| Cheechoo | Joanne | 492 003 744 |

**G. Base wage/Employment information** - (Do not include overtime here)

1. Is this worker (please check all that apply)

☑ Permanent full time ☐ Casual/Irregular ☐ Student ☐ Registered apprentice ☐ Owner operator or (sub) contractor
☐ Permanent part time ☐ Seasonal ☐ Unpaid/Trainee ☐ Optional insurance
☐ Temporary full time ☐ Contract
☐ Temporary part time ☐ Other

2. Regular rate of pay $ 80636 per ☐ hour ☐ day ☐ week ☑ other Year

**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 that line up with your pay periods that represent four full weeks immediately before the injury/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.

| Period | From date (dd/mm/yy) | To date (dd/mm/yy) | Mandatory overtime pay | Voluntary overtime pay | Use these spaces for any other earnings (indicate Commission, Differentials, Premiums, Bonus, Tips, In Lieu %, etc.). -Choose one- | -Choose one- | -Choose one- | -Choose one- |
|---|---|---|---|---|---|---|---|---|
| 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 that line up with your pay periods that represent four full weeks immediately before the injury/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 | Official title | |
|---|---|---|
| Kurtis Kannus | HR Assistant | |
| Signature | Telephone | Date |
| | 807-620-0294 | Sept 27th, 2024 |

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

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| Claim number |
| --- |
| |

| Last name | First name | Social Insurance Number |
| --- | --- | --- |
| **Cheechoo** | **Joanne** | **492 003 744** |

**K. Additional information**

**The Workplace Safety and Insurance Board Act requires you give a copy of this form to your worker**