wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Head Office:
200 Front Street West
Toronto, Ontario
Canada M5V 3J1

Siège social :
200, rue Front Ouest
Toronto, Ontario
Canada M5V 3J1

Telephone / Téléphone :
416-344-1000
1-800-387-0750
TTY / ATS : 1-800-387-0050

Fax / Télécopieur :
416-344-4684
1-888-313-7373

April 3, 2018

NISHNAWBE-ASKI LEGAL SERVICES CORPORATION
86 CUMBERLAND ST S
THUNDER BAY ON P7B 2V3
CANADA

Claim No.: 30782837
Worker Name: SHIRLEY KESSICK
Date of Injury/Illness: 18/Jan/2018
Injury/Illness: Right Foot

Dear NISHNAWBE-ASKI LEGAL SERVICES CORPORATION,

To keep you informed of the claim status, attached is a copy of a letter sent to SHIRLEY KESSICK.

Yours sincerely,

Operations Division
Tel: 416-344-1000 or 1-800-387-0750

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April 3, 2018

SHIRLEY KESSICK
105 DETTA RD
PO BOX 114
BALMERTOWN ON P0V 1C0
CANADA

Claim No.: 30782837
Worker Name: SHIRLEY KESSICK
Date of Injury/Illness: 18/Jan/2018
Injury/Illness: Right Foot

Dear SHIRLEY KESSICK,

This letter is further to our telephone conversation on April 3, 2018.

The information we currently have on file about your claim tells us that you are working your regular duties and that you are not losing any of your regular wages. Given the nature of your injury and the medical information we have received, we anticipate that you will fully recover from your injury by April 18, 2018. If you feel you are not recovering as expected or your family doctor refers you for further medical testing such as an MRI or to a specialist; please contact me to discuss further.

Helping in Your Recovery and Return to Work

Workers, employers and the WSIB all have responsibilities as workplace partners, with many of them required under the *Workplace Safety and Insurance Act*. Throughout the return to work and recovery process, you are required to keep up with health care treatments, stay in touch with your employer, and provide the WSIB with the information we request to manage your claim.

If you have not done so already, you can help us better manage your claim by submitting a completed Worker's Report of Injury/Illness to receive benefits from the WSIB. The Form 6 is available online at www.wsib.on.ca or by calling a WSIB representative.

You must report the following changes in your circumstances to the WSIB within 10 days of the change to ensure the benefits you are receiving are not reduced or stopped, and that you are not subject to a penalty:

- An improvement or worsening in your condition,
- An increase or decrease in your wages,
- Beginning to get, or changes, to Canada Pension Plan disability benefits,
- A change in your job duties or hours, and/or
- A change in your ability to co-operate in treatment, early and safe return-to-work activities, or work reintegration program.

Please contact us if you are unsure if you need to report a material change. We can review the information and decide if adjustments to your benefits are necessary.

As part of our responsibilities, the WSIB is committed to protecting your privacy and the confidentiality of your personal information. You can read our detailed privacy statement for workers on our website or contact us to send you a copy.

About Health Care Services/Equipment and/or Supplies

As a result of your injury or illness, you may need health care services to treat your work-related injury or illness. Pharmacies and health care providers should bill the WSIB directly at the approved fee and should not bill you for any services you receive. Sometimes a service may need to be pre-approved to ensure the service will be allowed. In these cases, the health care provider should contact the WSIB to obtain approval.

Before you purchase any special health care equipment and/or supplies, please contact a WSIB representative to confirm approval. We have three suppliers of medical supplies and equipment and they bill the WSIB directly so you do not need to pay. You can expect quality service, including next-day home delivery to anywhere in Ontario and a wide range of products. The suppliers you may use are:

- Medical Mart, at 1-866-893-0547 ext. 313, **www.medimart.com.**
  They carry all medical supplies and equipment.
- Motion Specialties, at 1-800-267-2920, **www.themotiongroup.com.**
  They carry medical supplies and equipment and have storefront locations, accept online and email orders.
- Shoppers HomeHealthCare, at 1-877-752-8885, **www.shoppershomehealthcare.ca.**
  They carry all medical supplies and equipment, and have storefront locations.

Health Care Benefits

The WSIB has an automated drug benefit program. This lets pharmacies across Canada bill us electronically for medication prescribed for a work related injury/illness that has been allowed by the WSIB.

To get your prescription filled, simply take your prescription to a Canadian pharmacy. Your pharmacist will need your claim number to process your prescription. The prescription information is sent electronically through the WSIB"s on-line system and if you have entitlement to this drug, then the pharmacist can fill your prescription immediately and bill the WSIB.

Sometimes you may have to pay for your prescription and then request reimbursement from the WSIB. This happens if:

- Your claim is not yet approved or you have not used the pharmacy billing system before. For new claims, call 1-800-655-4631 to check your status.
- A particular medication is not covered.
- The quantity of the drug requested is more than your entitlement. The WSIB is still reviewing entitlement to a particular medication.

Reimbursement for a prescription that you paid can be requested. You must:

- Complete and sign a WSIB Medication Reimbursement Form (0806A), which is available from pharmacies and the www.wsib.on.ca or by calling the above noted number.
- Attach the original receipts, and
- Send it to the WSIB for consideration of payment to:

  Drug Verification
  Workplace Safety and Insurance Board
  200 Front Street West
  Toronto ON M5V 3J1

The WSIB pays all reasonable expenses incurred when, on the direction or approval of the WSIB, a worker or another person designated by the WSIB, must travel in relation to a claim.

If you are not sure of the type of travel expenses for which you are eligible, please call the WSIB or visit our website, www.wsib.on.ca for more information. A Worker's Travel Expense Form is available on the website to complete. We must pre-approve travel expenses. Please complete the form based on the method of travel we have approved, even if you choose to travel a different method. For example, if you are eligible for public transit fare and choose to drive, you should complete the form claiming transit fares. Be sure to provide all the information requested so that we can process your payment promptly.

Additional Support for Workers

Some workers find it helpful to have a worker representative assist them with their WSIB case. Free advice and representation may be available through your local union or through the following organizations:

- The Ontario Federation of Labour (OFL), toll free at 1-800-668-9138.
- The Office of the Worker Adviser (OWA), toll free at 1-800-435-8980.
- Community Legal Clinics. Legal Aid Ontario toll free at 1-800-668-8258.

If you have any questions about this letter or your claim, please contact us.

Laura Ramage
Case Manager
Service Delivery

Tel: 416-344-1000 or 1-800-387-0750

Copy To:NISHNAWBE-ASKI LEGAL SERVICES CORPORATION

Jeff Robert

From: Shirley Keesic <skeesic@nanlegal.on.ca>
Sent: February-23-18 12:10 PM
To: Vernon Morris
Cc: Jeff Robert; Chantelle Johnson; hr@nanlegal.on.ca
Subject: SKEESIC WSIB #30782837 (Form 6) Feb 23 2018 attached for your files/info
Attachments: SKEESIC WSIB 30782837 PG1.pdf; SKEESIC WSIB 30782837 PG2.pdf; SKEESIC WSIB 30782837 PG3.pdf; SKEESIC WSIB 30782837 PG4.pdf; SKEESIC WSIB 30782837 PG5.pdf; SKEESIC WSIB 30782837 PG6.pdf

Faxed to WSIB today.

Kind meegwetch,

Shirley Keesic
"Maa-mii-nah-chi-ke-win"
(Setting things right)
Restorative Justice Worker
Balmertown, ON P0V 1C0
Toll-free: 1-888-662-6601
Direct: 1-807-735-2709
Confidential Fax: 1-807-735-2727
Email: skeesic@nanlegal.on.ca

Nishnawbe-Aski Legal Services Corporation

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Mailing Address:

86 S. Cumberland Street
Thunder Bay, Ontario
P7B 2V3

Tel: (807) 622-1413
Fax: (807) 622-3024

Email:
info@nanlegal.on.ca

Website:
www.nanlegal.on.ca

Head Office:

109 Mission Road
Fort William First Nation
Thunder Bay, Ontario
P7J 1K7

FAX COVER

DATE: February 23, 2018 ✓

TO: WSIB, Toronto ✓

FAX: 1-416-344-4684 / 888-313-7373

FAXED @10:54 AM

FROM: Shirley Keesic, Restorative Justice Worker, Balmertown

Re: **WSIB Claim 30782837**

Kind meegwetch,

Shirley Keesic

Shirley Keesic
Balmertown Site Office
NAN Legal Services
11 Dexter Road, BALMERTOWN, ON.
Phone: 1-807-735-2709
Fax: 1-807-735-2727

5 pgs faxed including this cover sheet

Nishnawbe-Aski Legal Services Corporation

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Mailing Address:

86 S. Cumberland Street
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Tel: (807) 622-1413
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Email:
info@nanlegal.on.ca

Website:
www.nanlegal.on.ca

Head Office:

109 Mission Road
Fort William First Nation
Thunder Bay, Ontario
P7J 1K7

FAX COVER

DATE: February 23, 2018 ✓

TO: WSIB, Toronto ✓

FAX: 1-416-344-4684 / 888-313-7373 FAXED @10:54 AM

FROM: Shirley Keesic, Restorative Justice Worker, Balmertown

Re: **WSIB Claim 30782837**

Kind meegwetch,

Shirley Keesic
Balmertown Site Office
NAN Legal Services
11 Dexter Road, BALMERTOWN, ON.
Phone: 1-807-735-2709
Fax: 1-807-735-2727

5 pgs faxed including this cover sheet

wsib cspaat ONTARIO — Workplace Safety & Insurance Board / Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail To:
Workplace Safety and Insurance Board
200 Front Street West
Toronto ON M5V 3J1

OR Fax To:
416-344-4684
OR 1-888-313-7373

6 Worker's Report of Injury/Disease (Form 6)

Claim Number: 30782837

Please PRINT in black ink

A. Worker Information

Last Name: KEESICK	First Name: SHIRLEY	Social Insurance Number: 455 | 418 | 293
Address (number, street, apt., suite, unit): BOX 114, 105 DETTA ROAD		Telephone: 807 |735-2628
City/Town: BALMERTOWN	Province: ON / Postal Code: P0V 1C0	Alternate/Cell Phone: 807 |735-2709
Job Title/Occupation (at the time you were hurt): RESTORATIVE JUSTICE WORKER	Date you started with employer: dd 07 | mm 03 | yy 11	How long have you been doing this job for this employer? 6 YRS
Only check if you are one of the following: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer		Date of Birth: dd 19 | mm 6 | yy 57
Sex: ☐ M ■ F	Your Preferred Language: ■ English ☐ French ☐ Other	Would an interpreter be helpful? ☐ yes ☐ no
Are you a member of a union? ☐ yes ■ no	Do you authorize your union to represent you in this claim? ☐ yes ☐ no	If **yes**, do you consent to the disclosure of verbal claim file status information to your union representative? ☐ yes ☐ no
Provide your Union Name and Local		

B. Employer Information

Company/Employer Name: Nishnawbe-Aski Legal Services Corp.		
Address: 86 Cumberland Street South		
City/Town: Thunder Bay	Province: ON	Postal Code: P7B 2V3
Your Immediate Supervisor's Name: Vernon Morris		Company Telephone: NAN |807-737-7701

C. Accident/Illness Dates & Details

1. Date and hour of accident/Awareness of illness: dd 18 \| mm 01 \| yy 18 \| 2:00 ☐ AM ■ PM

Date and hour reported to employer: dd 12 \| mm 02 \| yy 18 \| 9:00 ■ AM ☐ PM

2. Who did you report this accident/illness to? (Name & Position): Chantelle Johnson, Program Assistant

Telephone: 807 \|622-1413

3. Area of Injury (Body Part) - **(Please check all that apply)**

☐ Head ☐ Face ☐ Eye(s) ☐ Ear(s) ☐ 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 ■

☐ Other: _____

Are you: ☐ Left Handed ■ Right handed

4. Did the accident/illness happen on the employer's property or work site? ☐ yes ■ no

Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.): Ballroom I, Valhalla Inn, Thunder Bay, ON

5. Did it happen outside the Province of Ontario? ☐ yes ■ no

If **yes**, indicate where (city, province/state, country):

6. Have you hurt this area(s) of your body before? ■ yes ☐ no

7. Do you have any prior related WSIB/WCB claims? ■ no ☐ yes - In Ontario ☐ yes - Outside Ontario

A guide to complete this form is available at www.wsib.on.ca

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Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

6 Worker's Report of Injury/Disease (Form 6)

Claim Number 30782837

Please PRINT in black ink

Worker Name - Last Name	First Name	Social Insurance Number
KEESICK	SHIRLEY	455 | 418 | 293

C. Accident/Illness Dates & Details (continued)

8. If you had a sudden type of accident/illness, describe your injury and what happened to cause it (e.g. hurt lower back while lifting a 50 pound box, sprained left ankle when I slipped on a wet floor, used a new cleaner and immediately got a rash). Please indicate the size, weights and names of any objects involved.
or
If you had a gradual onset type of injury, describe your injury, the work that you do and what you believe caused your injury/condition.

While attending the "BY-LAW Conference" January 15-19, 2018, at the Valhalla Inn,Thunder Bay, during a session, I got off my chair, turned left & stumbled on briefcase that was on the floor. I caught myself and removed obstacle to the outer wall so that no one else would stumble on it.

9. When did you first start to have problems with this injury/condition?
Jan. 22, 2018. My right foot was red, swollen, painful to touch.

10. If you did not report this to your employer right away, please tell us the reason why.
I thought nothing about it at the time because this occurred on my left foot a year ago with bruising only.

11. If there were any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, give us their names & positions.

Name	Position
1. Vernon Morris	Manager RJ West
2. Chantelle Johnson	RJ Assistant

12. The Workplace Safety and Insurance Act requires your employer to give you a copy of the Employer's Report of Injury/Disease (Form 7).
Did you receive a copy of the Form 7? ■ yes ☐ no

The Workplace Safety and Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer.

D. Health Care Information

Give your Health Professional your WSIB Claim number.

1. Did you get first aid or care at work ☐ yes ■ no If yes, when dd mm yy and by whom (Name):

2. Where did you go for health care, for your injury, outside of work? **(Check all that apply)**

	Facility/Hospital (Name & Address)	Date of Visit (dd/mm/yy)		Date of Visit (dd/mm/yy)
☐ Nursing Station ■ Emergency Department ☐ Admitted to Hospital	Red Lake Margaret Cochenour Memorial Hopsital	29 | 01 | 18	☐ Ambulance ☐ Health Professional Office ■ Clinic	29 | 01 | 18

3. Were you prescribed any medications/drugs? ■ yes ☐ no

4. Were you referred for any other treatment or tests? ■ yes ☐ no

5. Did you talk to your health professional about going back to regular or modified work? ■ yes ☐ no If yes, were you given any work limitations? ■ yes ☐ no

6. Did you tell your employer you went for medical treatment? ■ yes ☐ no **If no, please tell your employer right away.**

If yes, when? dd 12 \| mm 02 \| yy 18 and to whom? Name Jeff Robert
Position Human Resources

wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

6 Worker's Report of Injury/Disease (Form 6)

Claim Number: 30782837

Please PRINT in black ink

Worker Name - Last Name	First Name	Social Insurance Number
KEESICK	SHIRLEY	455 | 418 | 293

E. Lost Time & Return to Work

1. After the day of accident/illness:

- ☐ I returned to work to my **regular job** and **did not** lose any time or pay.
- ■ I returned to **modified duties** and **did not** lose any time or pay.
- ☐ **I lost time and/or pay** (e.g. regular pay, shift differential, bonuses, premiums, etc.).

→ Date you first lost time and/or pay: dd | mm | yy

2. If you lost time, have you returned to work? ☐ yes ☐ no

If **yes** ▶ Date of your return to work: dd | mm | yy ☐ regular work ☐ modified work

If **no** ▶ Did you discuss return to work with your employer? ☐ yes ☐ no

Does your employer have modified work? ☐ yes ☐ no

F. Earnings (Do not include overtime here)

1. Rate of pay: $ 28.57 per ■ hour ☐ week ☐ other: _____

2. Usual number of pay hours: 35 per ■ week ☐ other: _____

3. If you lost time from work after the day of accident/illness, did your employer continue to pay you? ☐ yes ☐ no

4. Have you applied for, or did you receive, any other benefits (money) while off work (e.g. EI benefits, sick benefits, social services, insurance, etc.). ☐ yes ■ no

5. At the time of the accident/illness did you work for more than one employer? ☐ yes ■ no

G. Declarations and Signature

By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the WSIB's "Functional Abilities Form for Planning Early and Safe Return to Work".

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.

Signature	Date (dd/mm/yy)
Shirley Kee	23 | 02 | 18

If you are under the age of 16, your parent or guardian, must authorize the release of the functional abilities information.

Signature	Relationship:	Date (dd/mm/yy)	Telephone
			( )

Personal information about you will be collected throughout your claim under the authority of the *Workplace Safety and Insurance Act*, 1997. Your personal information will be used to administer your claim(s) and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, Canada Revenue Agency (CRA), and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax receipts and is collected under the authority of the Income Tax Act. Information may only be disclosed to the employer, external medical, vocational, and safety agencies, external payment and service providers, researchers, third parties for cost recovery purposes and others as authorized by the *Workplace Safety and Insurance Act* and the *Freedom of Information and Protection of Privacy Act*. Your name and telephone number may be disclosed to third party researchers conducting satisfaction surveys and focus groups. Incoming and outgoing calls may be recorded for quality assurance purposes. Questions about this collection should be directed to the decision maker responsible for your file or by calling 1-800-387-0750.

A more detailed PRIVACY STATEMENT for workers may be found at www.wsib.on.ca or by calling toll free at 1-800-387-0750.

0006A3

wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

6 Worker's Report of Injury/Disease (Form 6)

Claim Number: 30782837

Please PRINT in black ink

Worker Name - Last Name	First Name	Social Insurance Number
KEESICK	SHIRLEY	455 418 293

K. Additional Information

The Workplace Safety & Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer

0006A4

TRANSMISSION VERIFICATION REPORT

Claim 30782837

TIME : 02/23/2018 10:54
NAME : NAN LEGAL BALMERTOWN
FAX : 18077352727
TEL : 18077352709
SER.# : U63274B7J399215

DATE,TIME	02/23 10:53
FAX NO./NAME	18883137373
DURATION	00:01:37
PAGE(S)	05
RESULT	OK
MODE	STANDARD ECM

Confirm fx. WSIB-TORONTO
S. Keesic foot injury

wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail To:
200 Front Street West
Toronto ON M5V 3J1

OR FaxTo:
416-344-4684
OR 1-888-313-7373

42 Employer's Progress Report (Form 42)

Claim Number: 30782837

Please PRINT in black ink

Worker's Name	Worker Reference Number	Injury	Original Date of Accident/Injury
SHIRLEY KESSICK		Right Foot	18/Jan/2018

1. Choose **one** of the following which best describes the worker's current situation and complete remainder of form as indicated.

- ☐ This worker **has not** lost time or pay from work (complete **only** questions **2 and 3**)
- ☒ This worker **has** lost time and **has** returned to work (complete **only** questions **2 to 5**)
- ☐ This worker **has** lost time and **has not** returned to work (complete **only** questions **6 to 10**)

2. The worker returned to (check all that apply)

a) ☒ regular work **OR** ☐ modified work
b) ☐ regular pay **OR** ☐ reduction in pay
c) ☐ regular hours **OR** ☐ reduction in hours

3. a) Indicate the return to work status

Return to work plan in place? ☐ yes ☐ no
Plan on schedule? ☐ yes ☐ no

b) Do you want WSIB assistance with this return to work? ☐ yes ☐ no

Provide any explanation/details on this worker's return to work.

will be attending doctor's appointment to determine extent of injury

4. Date and time of return to work dd mm yy: | | ☐ AM ☐ PM

5. a) Total number of shifts/days lost: 2 day

b) If worker is repeating rotational shift work provide the length of each shift/day lost (e.g. 4 days on, 4 days off - OR - works a set schedule 5 days per week but days worked each week vary):

6. Who is responsible for arranging this worker's return to work?

☐ myself ☐ other — name | position | phone | ext.

7. Has contact been made with this worker to discuss his/her status and return to work? ☐ yes ☐ no — Explanation/Details

If **yes**, date of last contact/discussion dd mm yy: | What was the outcome of that discussion?

8. Have you received this worker's work limitations or functional abilities for a return to work? ☐ yes ☐ no

If **yes**, when did you receive them? dd mm yy: | How did you receive them? ☐ WSIB Functional Abilities Form ☐ medical note ☐ your own Functional Abilities Form ☐ other

9. Are you able to accommodate this worker? ☐ yes ☐ no

10. Please outline why the worker has not returned to work?

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 this page is true.

Name of person completing this report (please print)	Official title		
Signature	Phone	Ext.	Date (dd/mm/yy)

wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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Fax / Télécopieur :
416-344-4684
1-888-313-7373

February 27, 2018

NISHNAWBE-ASKI LEGAL SERVICES CORPORATION
86 CUMBERLAND ST S
THUNDER BAY ON P7B 2V3
CANADA

Claim No.: 30782837
Worker Name: SHIRLEY KESSICK
Date of Injury/Illness: 18/Jan/2018
Injury/Illness: Right Foot

Dear NISHNAWBE-ASKI LEGAL SERVICES CORPORATION

The Workplace Safety and Insurance Board (WSIB) requires regular updates to monitor the above-named worker's progress and to proceed with this claim.

Please complete Question 1 on the Employer's Progress Report and, based on your response, the appropriate questions thereafter.

If this worker has returned to work, the WSIB needs to be provided with those details. If there has not been a return to work, there is a shared accountability that you and your employee continue to communicate to review the worker's recovery progress and to assess when it may be possible to return to regular or suitable employment.

Legislative Reference - *Workplace Safety and Insurance Act* Section 40(1) (R.S.O. 1997)

The employer of an injured worker shall co-operate in the early and safe return to work of the worker by:

a) Contacting the worker as soon as possible after the injury occurs and maintaining communication throughout the period of the workers recovery and impairment;
b) Attempting to provide suitable employment that is available and consistent with the worker's functional abilities and that, when possible, restores the worker's pre-injury earnings;
c) Giving the Board such information as the Board may request concerning the worker's return to work; and
d) Doing other such things as may be prescribed.

Please contact us if you are unable to arrange for early and safe return to work as we may be able to help. If you have any questions or need to provide any additional details, please contact us at the above noted number.

Yours sincerely,

Operations Division

Tel: 416-344-1000 or 1-800-387-0750
Encl: Employer's Progress Report (Form 42)

wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Head Office:
200 Front Street West
Toronto, Ontario
Canada M5V 3J1

Siège social :
200, rue Front Ouest
Toronto, Ontario
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Telephone / Téléphone :
416-344-1000
1-800-387-0750
TTY / ATS : 1-800-387-0050

Fax / Télécopieur :
416-344-4684
1-888-313-7373

February 28, 2018

Claim No.: 30782837

NISHNAWBE-ASKI LEGAL SERVICES CORPORATION
86 CUMBERLAND ST S
THUNDER BAY ON P7B 2V3
CANADA

Worker Name: SHIRLEY KESSICK

Date of Injury/Illness: 18/Jan/2018

Injury/Illness: Right Foot

Dear NISHNAWBE-ASKI LEGAL SERVICES CORPORATION,

An early and safe return to work program can minimize your costs and return your trained and valued employees to work earlier and more effectively.

One tool to assist you in achieving this is a detailed job description and physical demands analysis of the pre-injury job. The job description or Physical Demands Analysis (PDA) can help determine if the worker is physically able to perform the essential duties of the pre-injury job.

The Workplace Safety and Insurance Board (WSIB) is responsible for monitoring a worker's return to work activities and progress, and determining whether a worker is fit to perform the essential duties of his or her pre-accident job.

Understanding SHIRLEY KESSICK's level of fitness will be more comprehensive if you send a detailed description and PDA of the pre-accident injury job to the file. If you do not have a PDA, a Physical Demands Information Form (PDIF) is available from the WSIB website, www.wsib.on.ca. While the PDIF is not a complete PDA, it does collect key information about the physical demands of a job as they relate to a worker's specific area(s) of injury and can assist you to identify potential risk factors for injuries when facilitating a return to work.

Thank you for your help. If you have any questions, please call us at the above-noted number.

Yours sincerely,

Laura Ramage
Case Manager
Service Delivery

Tel: 416-344-1000 or 1-800-387-0750

Nishnawbe-Aski Legal Services Corporation

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Fax Cover

Date: Feb 12/18

To: WSIB

Fax: ~~80~~ 416-344-4684

From: Jeff Robert, HR Generalist-

Re: Form 7 Shirley Keesic-

Message:

We are transmitting the following 5 pages (including this cover letter). If you do not receive all pages, please call us as soon as possible.

Telephone: 1-800-465-5581 Fax: 807-622-3024

Contact: _____

THE INFORMATION CONTAINED IN THIS TELECOPY IS INTENDED FOR THE USE OF THE RECIPIENT ABOVE. The telecopy may contain privileged, confidential, or undisclosed information. If the reader of this telecopy is not the intended recipient, you are hereby notified that you have received this telecopy in error, and that any review, dissemination, distribution, or copying of it is strictly prohibited. If you have received this in error, please notify us immediately by telephone and return the original transmittal to us by mail. Thank you for your cooperation.

Mailing Address:

86 S. Cumberland Street
Thunder Bay, Ontario
P7B 2V3

Tel: (807) 622-1413
Fax: (807) 622-3024

Email:
info@nanlegal.on.ca

Website:
www.nanlegal.on.ca

Head Office:

109 Mission Road
Fort William First Nation
Thunder Bay, Ontario
P7J 1K7

wsib cspaat ONTARIO

Mail To:
200 Front Street West
Toronto ON M5V 3J1

OR To:
4[illegible]4-4684
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): **Restorative Justice Worker**

Length of time in this position while working for you: **6 Years**

Social Insurance Number: **4 5 5 4 1 8 2 9 3**

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

Last Name: **Kessick**

First Name: **Shirley**

Address (number, street, apt., suite, unit): **105 Betta Rd. Box 114**

City/Town: **Balmertown**

Province: **ON**

Postal Code: **P0V 1C0**

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): **1 9 0 6 5 7**

Telephone: **807-622-1413**

Sex ☐ M ☒ F

Date of Hire (dd mm yy): **0 7 0 3 1 1**

B. Employer Information

Fold here for #10 envelope

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

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

Mailing Address: **86 Cumberland St S.**

Rate Group Number:

Classification Unit Code:

City/Town: **Thunder Bay**

Province: **ON**

Postal Code: **P7B 2V3**

Telephone:

Description of Business Activity: **Justice**

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): **11 Dexter Rd.**

City/Town: **Balmertown**

Province: **ON**

Postal Code: **P0V 1C0**

Alternate Telephone:

C. Accident/Illness Dates and Details

1. Date and hour of accident/Awareness of illness (dd mm yy): **2 9 0 1 1 8** ☐ AM ☒ PM

Date and hour reported to employer (dd mm yy): **1 2 0 2 1 8** 9:00 ☒ AM ☐ PM

2. Who was the accident/illness reported to? (Name & Position): **Chantelle Johnson, Program Assistant**

Telephone: **807-622-1413** Ext.

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)
☐ 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 ☒
☐ 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.**

Shirley Keesic attended the By-Law Conference the week of Jan 15-19, 2018, at the Valhalla Inn Thunder Bay. ON Thursday Jan 18, 2018, afternoon session, Shirley did not notice the briefcase that was placed on the floor, left by a co-worker Chantelle Johnson. Once the speaker at the time completed, Shirley got off her chair, turned left and her right foot caught on the briefcase, and she stumbled forward but did not fall. Jan 22, 2018 it had slowly started to turn red and got sore. Jan 29, 2018 Shirley saw Dr. Gloster and was sent for x-rays.

X-ray determined foot was broken.

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Please PRINT in black ink

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

Claim Number

Worker Name: Kessick Shirley

Social Insurance Number: 4 5 5 4 1 8 2 9 3

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..).

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 receive health care for this injury? ■ yes ☐ no
If **yes,** when: dd mm yy 18 01 18

2. When did the employer learn that the worker received health care? dd mm yy 12 02 18

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)
Dr. Gloster, Ph: 807-727-2617
51 G Highway 105, Red Lake, 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
☐ regular work ☐ modified work

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

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 _____ Ext. _____

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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
Kessick	Shirley	455 418 293

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)	Official title	
Jeff Robert	HR Generalist	
Signature	Telephone / Ext.	Date dd mm yy
	807-766-7074	13 02 18

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
Kessick	Shirley	4 5 5 4 1 8 2 9 3

K. Additional Information

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

RE: Shirley Keesick, WSIB #30782837

MARCH 19, 2018 @ 9:00 AM appointment. It will take a couple of weeks for them to mail me my 'insoles' for my footwear. The card below is who I saw & he took the foot impressions.

FYI/file

S Keesick
Mar. 22, 2018

Thunder Bay Orthopaedic Inc.

Northwestern Ontario's
Orthotic and Pedorthic Professionals

DAVID CARROLL
H.Kin., C.Ped(c)
Certified Pedorthist

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