Transmission Report

Date/Time	09-19-2024	04:48:25 p.m.	Transmit Header Text	
Local ID 1	8076221096		Local Name 1	nalsc

This document : Confirmed
(reduced sample and details below)
Document size : 8.5"x11"

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
Victim Witness Liaison Worker	4 Months	447-519-893

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?
Longpeter	Lucie	☐ yes ☒ no

Address (number, street, apt., suite, unit)	City/Town	Province	Worker's preferred language
23-33 Walkover Avenue	Thunder Bay	ON	☒ English ☐ French ☐ Other

Postal code	Telephone	Sex	Date of birth (dd/mm/yy)	Date of hire (dd/mm/yy)
P7B 1L1	(807) 357-8785	☐ M ☒ F	10/02/1954	29/04/2024

B. Employer Information

Trade and Legal name (if different provide both)	Check one:	Provide number
Nishnawbe-Aski Legal Services Corporation	☐ Firm number ☒ Account number	6426085

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)
101 Syndicate North Suite 101

City/Town	Province	Postal code	Alternate telephone
Thunder Bay	ON	P7C 3V4	(807) 622-1413

C. Accident/Illness dates and details

1. Date and hour of accident/Awareness of illness: Sept 16, 2024 6:30 ☐ AM ☒ PM
   Date and hour reported to employer: Sept 16, 2024 7:56 ☐ AM ☐ PM
2. Who was the accident/illness reported to? (name and position): Alana Odawa-Lindstone, Manager Victim Witness Program — Telephone (807) 631-2857
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 ☐ Other ☐ Fire/Explosion ☐ Fall ☐ Harmful substances/environmental ☐ Assault ☐ 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
   ☒ Other: No physical injury
   Left/Right: ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Finger(s) ☐ Hip ☐ Thigh ☐ Knee ☐ Lower leg ☐ Ankle ☐ Foot ☐ Toe(s)
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 had picked up a rental car for work travel the following day. In a residential area she hit a dear at 6:30pm on September 16th, 2024. The sun was still bright and she was wearing prescription sunglasses. No physical injury was reported and she did not seek medical treatment. The car had damage on the front left bumper.

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)
wsib.ca | Mail: 200 Front Street West, Toronto, Ontario, M5V 3J1 | Toll free: 1-800-387-0750 | TTY: 1-800-387-0050 | Fax: 1-888-313-7373
0007A (03/24)

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	334	WSIB	04:21:30 p.m. 09-19-2024	00:03:58	4/4	1	G3	HS	CP12000

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

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
Victim Witness Liaison Worker	**4 Months**	**447-519-893**

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?
Longpeter	**Lucie**	☐ yes ☒ no

Address (number, street, apt., suite, unit)	City/Town	Province	Worker's preferred language
23-33 Walkover Avenue	**Thunder Bay**	**ON**	☒ English ☐ French ☐ Other

Postal code	Telephone	Sex	Date of birth (dd/mm/yy)	Date of hire (dd/mm/yy)
P7B 1L1	**(807) 357-8785**	☐ M ☒ F	**10/02/1954**	**29/04/2024**

B. Employer information

Trade and Legal name (if different provide both)	Check one:	Provide number
Nishnawbe-Aski Legal Services Corporation	☐ Firm number ☒ Account number	**6426085**

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)

101 Syndicate North Suite 101

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

C. Accident/illness dates and details

1. Date and hour of accident/Awareness of illness

Sept 16, 2024 **6:30** ☐ AM ☒ PM

Date and hour reported to employer

Sept 16, 2024 **7:56** ☐ AM ☒ PM

2. Who was the accident/illness reported to? (name and position)

Alana Odawa-Lindstone
Manager Victim Witness Program

Telephone: **(807) 631-2857**

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
- ☐ Other
- ☐ Fire/Explosion
- ☐ Fall
- ☐ Harmful substances/environmental
- ☐ Assault
- ☐ 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

☒ Other: **No physical injury**

Left		Right	Left		Right	Left		Right	Left		Right
☐	Shoulder	☐	☐	Wrist	☐	☐	Hip	☐	☐	Ankle	☐
☐	Arm	☐	☐	Hand	☐	☐	Thigh	☐	☐	Foot	☐
☐	Elbow	☐	☐	Finger(s)	☐	☐	Knee	☐	☐	Toe(s)	☐
☐	Forearm	☐				☐	Lower leg	☐			

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 had picked up a rental car for work travel the following day. In a residential area she hit a dear at 6:30pm on September 16th, 2024. The sun was still bright and she was wearing prescription sunglasses. No physical injury was reported and she did not seek medical treatment. The car had damage on the front left bumper.

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)

wsib ONTARIO | wsib.ca

Claim number

Last name	First name	Social Insurance Number
Longpeter	Lucie	447-519-893

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 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

wsib ONTARIO | wsib.ca

Claim number

Last name	First name	Social Insurance Number
Longpeter	Lucie	447-519-893

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

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

☐ 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 $ .... per ☐ 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 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.

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	-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.

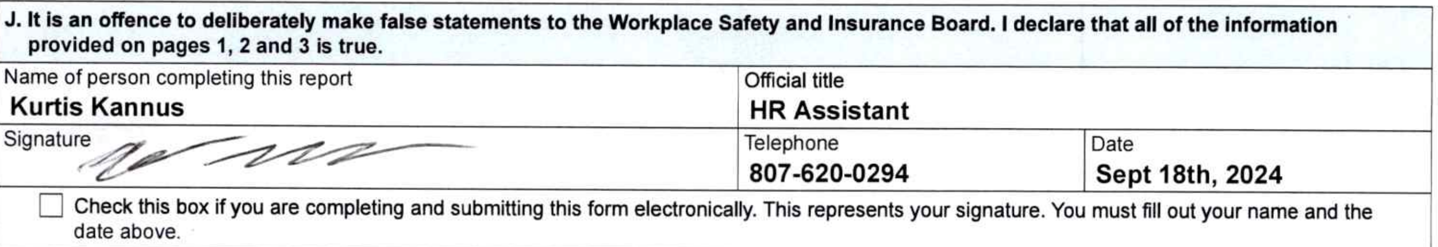
Number of days on	Number of days off	Hours per shift(s)	Number of weeks in cycle

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
[signature]	807-620-0294	Sept 18th, 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.

wsib ONTARIO | wsib.ca

Claim number

Last name	First name	Social Insurance Number
Longpeter	Lucie	447-519-893

K. Additional information

The worker contacted the rental company and her manager right after the accident. After she drove to a family member's house and then made her way home. She traveled for work the following day.

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