wsib ONTARIO

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

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

Toll free: 1-800-387-0750
TTY: 1-800-387-0050
wsib.ca

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

Claim Number:

Please PRINT in black ink

A. Worker Information

Field	Value
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	3 YRS/11 MTH
Social Insurance Number	552 942 328
Please check if this worker is a:	☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer
Last Name	Beardy
First Name	Christopher
Address (number, street, apt., suite, unit)	PO BOX 58
City/Town	Pikangikum,
Province	ON
Postal Code	P0V2L0
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)	14 06 93
Telephone	807-738-1678
Sex	☑ M ☐ F
Date of Hire (dd mm yy)	04 02 19

Fold here for #10 envelope

B. Employer Information

Field	Value
Trade and Legal Name (if different provide both)	Nishnawbe-Aski Legal Services
Check one:	☐ Firm Number OR ☑ Account Number
Provide Number	6426085
Mailing Address	101 Syndicate St. N, Suite 303A
Class/Subclass	
NAICS Code	
City/Town	Thunder Bay
Province	ON
Postal Code	P7C3V4
Telephone	807-622-1413
Description of Business Activity	Non Profit
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 mm yy): 28 01 24 — 11:30 ☒ AM ☐ PM

Date and hour reported to employer (dd mm yy): 29 01 24 — 4:00 ☐ AM ☑ PM

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

Telephone: 807-633-8158 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) ☐ Other
- ☐ Teeth ☐ Neck ☐ Chest
- ☐ Upper back ☑ Lower back ☐ Abdomen ☐ Pelvis
- Left/Right: ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm
- Left/Right: ☐ Wrist ☐ Hand ☐ Finger(s)
- Left/Right: ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg
- Left/Right: ☐ 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 occurred gradually over time, please attach a description of the physical activity required to do the work.**

Christopher Beardy was travelling for work on January 28, when he bent over to pick up his luggage, he hurt his back and was not able to stand up straight.

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7 Employer's Report of Injury or Illness (Form 7)

Claim Number

Please PRINT in black ink

Worker Name		Social Insurance Number
Beardy	Christopher	552 942 328

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 29 01 24

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: Nursing Station

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 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: Beardy Christopher

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

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 $ 60904.00 per [ ] hour [ ] day [ ] week [x] other ANNUAL SALARY

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): Melissa Scholz

Official title: HRIS/Training Coordinator

Signature: [signature]

Telephone: 807-632-9142 Ext.

Date dd mm yy: 30 01 24

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