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)

Please PRINT in black ink

Claim Number

A. Worker Information

Job Title/Occupation (at the time of accident/illness - do not use abbreviations): HR Manager

Length of time in this position while working for you: 3yrs

Social Insurance Number: 483 354 643

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

Last Name: Shwetz
First Name: Colette
Address (number, street, apt., suite, unit): 12 First St
City/Town: Nipigon
Province: ON
Postal Code: P0T2J0

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): 23 09 66

Telephone:

Sex: ☐ M ☑ F

Date of Hire (dd mm yy): 02 14 19

B. Employer Information

Fold here for #10 envelope

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

Check one: ☑ Firm Number OR ☐ Account Number — Provide Number: 6426085

Mailing Address: 1805 E Arthur St.

Class/Subclass:

NAICS Code:

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

Description of Business Activity: Indigenous Legal Office

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): 16 03 22 ☑ AM ☐ PM

Date and hour reported to employer (dd mm yy): 16 03 22 ☑ AM ☐ PM

2. Who was the accident/illness reported to? (Name & Position): Tara Thompson - Acting ED

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)

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

I arrived at work at 9:03am. When I got out of the vehicle in the staff parking lot, I immediately fell completely to the groud, on the ice. I fell directly on my tailbone and caught some of my fall with my left arm. There was recent light rain early in the morning making the parking lot exteremly slippery. There was no sand on the parking lot.

wsib ONTARIO | wsib.ca

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

Claim Number

Please PRINT in black ink

Worker Name: Shwetz Colette

Social Insurance Number: 4 8 3 3 5 4 6 4 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..). Staff Parking Lot

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. Holly Sitch. Discharge Coordinator - (807) 887-4175
   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
    Property Manager - CE Renovation - Failed to sand parking lot. 807-476-7621

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

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 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.

wsib ONTARIO | wsib.ca

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

Claim Number

Please PRINT in black ink

Worker Name: Shwetz Colette

Social Insurance Number: 4 8 3 3 5 4 6 4 3

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 $ 79,000 per [ ] hour [ ] day [ ] week [ ] 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): Colette Shwetz

Official title: HR Manager

Signature: Colette Shwetz

Telephone: 807-633-8858 Ext.

Date: dd 16 mm 03 yy 22

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

wsib ONTARIO | wsib.ca

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

Claim Number

Please PRINT in black ink

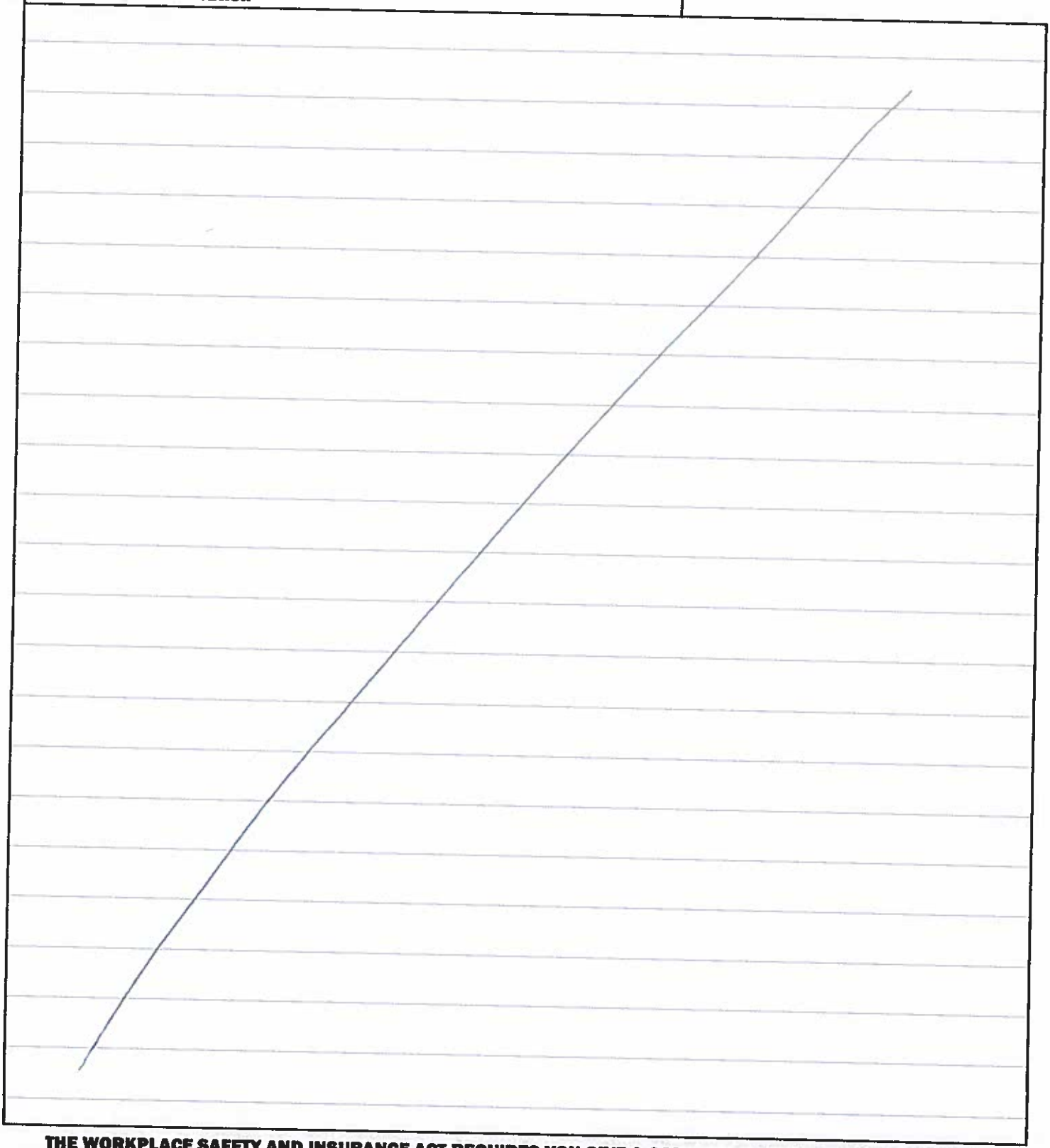
Worker Name

Shwetz Colette

Social Insurance Number

4 8 3 3 5 4 6 4 3

K. Additional Information



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