

Claim Number

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**A. Worker Information**

|                                                                                                                                                                                                                               |                                                                                                                            |                                |                                                                                                                                                                                    |                                                                                           |       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------|
| Last Name                                                                                                                                                                                                                     |                                                                                                                            | First Name                     |                                                                                                                                                                                    | Social Insurance Number                                                                   |       |
| Address (number, street, apt., suite, unit)                                                                                                                                                                                   |                                                                                                                            |                                |                                                                                                                                                                                    | Telephone                                                                                 |       |
| City/Town                                                                                                                                                                                                                     |                                                                                                                            | Province                       | Postal Code                                                                                                                                                                        | Alternate/Cell Phone                                                                      |       |
| Job Title/Occupation (at the time you were hurt)                                                                                                                                                                              |                                                                                                                            | Date you started with employer | dd mm yy                                                                                                                                                                           | How long have you been doing this job for this employer?                                  |       |
| <b>Only check if you are one of the following:</b><br><input type="checkbox"/> executive <input type="checkbox"/> elected official <input type="checkbox"/> owner <input type="checkbox"/> spouse or relative of the employer |                                                                                                                            | Date of Birth                  |                                                                                                                                                                                    | dd                                                                                        | mm yy |
| Sex<br><input type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                  | Your Preferred Language<br><input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other |                                |                                                                                                                                                                                    | Would an interpreter be helpful? <input type="checkbox"/> yes <input type="checkbox"/> no |       |
| Are you a member of a union?<br><input type="checkbox"/> yes <input type="checkbox"/> no                                                                                                                                      | Do you authorize your union to represent you in this claim?<br><input type="checkbox"/> yes <input type="checkbox"/> no    |                                | If <b>yes</b> , do you consent to the disclosure of verbal claim file status information to your union representative?<br><input type="checkbox"/> yes <input type="checkbox"/> no |                                                                                           |       |
| Provide your Union Name and Local                                                                                                                                                                                             |                                                                                                                            |                                |                                                                                                                                                                                    |                                                                                           |       |

**B. Employer Information**

|                                  |          |                   |
|----------------------------------|----------|-------------------|
| Company/Employer Name            |          |                   |
| Address                          |          |                   |
| City/Town                        | Province | Postal Code       |
| Your Immediate Supervisor's Name |          | Company Telephone |

**C. Accident/Illness Dates & Details**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                |                                                                                                                                                                               |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                               |                               |                                     |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |                                |                                  |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |  |                                 |                                                              |                                                              |                                                              |                                                              |                                                              |
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| <b>1. Date and hour of accident/Awareness of illness</b><br>dd mm yy AM <input type="checkbox"/> PM <input type="checkbox"/><br>Date and hour reported to employer<br>dd mm yy AM <input type="checkbox"/> PM <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                | <b>2. Who did you report this accident/illness to? (Name &amp; Position)</b><br>Telephone                                                                                     |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                               |                               |                                     |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |                                |                                  |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |  |                                 |                                                              |                                                              |                                                              |                                                              |                                                              |
| <b>3. Area of Injury (Body Part) - (Please check all that apply)</b><br><table border="0"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Teeth</td> <td><input type="checkbox"/> Upper back</td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Face</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Lower back</td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Eye(s)</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Abdomen</td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Ear(s)</td> <td></td> <td><input type="checkbox"/> Pelvis</td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> <td>Left <input type="checkbox"/> Right <input type="checkbox"/></td> </tr> </table> |                                |                                                                                                                                                                               |                                                              | <input type="checkbox"/> Head                                | <input type="checkbox"/> Teeth                               | <input type="checkbox"/> Upper back                          | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | <input type="checkbox"/> Face | <input type="checkbox"/> Neck | <input type="checkbox"/> Lower back | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | <input type="checkbox"/> Eye(s) | <input type="checkbox"/> Chest | <input type="checkbox"/> Abdomen | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | <input type="checkbox"/> Ear(s) |  | <input type="checkbox"/> Pelvis | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> |
| <input type="checkbox"/> Head                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Teeth | <input type="checkbox"/> Upper back                                                                                                                                           | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> |                                                              |                                                              |                                                              |                                                              |                               |                               |                                     |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |                                |                                  |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |  |                                 |                                                              |                                                              |                                                              |                                                              |                                                              |
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| <input type="checkbox"/> Ear(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                | <input type="checkbox"/> Pelvis                                                                                                                                               | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> | Left <input type="checkbox"/> Right <input type="checkbox"/> |                                                              |                                                              |                                                              |                                                              |                               |                               |                                     |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |                                |                                  |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |  |                                 |                                                              |                                                              |                                                              |                                                              |                                                              |
| <input type="checkbox"/> Other:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                | Are you: <input type="checkbox"/> Left Handed <input type="checkbox"/> Right handed                                                                                           |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                               |                               |                                     |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |                                |                                  |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |  |                                 |                                                              |                                                              |                                                              |                                                              |                                                              |
| <b>4. Did the accident/illness happen on the employer's property or work site?</b> <input type="checkbox"/> yes <input type="checkbox"/> no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                | Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):                                                                                   |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                               |                               |                                     |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |                                |                                  |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |  |                                 |                                                              |                                                              |                                                              |                                                              |                                                              |
| <b>5. Did it happen outside the Province of Ontario?</b> <input type="checkbox"/> yes <input type="checkbox"/> no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                | If <b>yes</b> , indicate where (city, province/state, country):                                                                                                               |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                               |                               |                                     |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |                                |                                  |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |  |                                 |                                                              |                                                              |                                                              |                                                              |                                                              |
| <b>6. Have you hurt this area(s) of your body before?</b> <input type="checkbox"/> yes <input type="checkbox"/> no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                | <b>7. Do you have any prior related WSIB/WCB claims?</b> <input type="checkbox"/> no <input type="checkbox"/> yes - In Ontario <input type="checkbox"/> yes - Outside Ontario |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                                                              |                               |                               |                                     |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |                                |                                  |                                                              |                                                              |                                                              |                                                              |                                                              |                                 |  |                                 |                                                              |                                                              |                                                              |                                                              |                                                              |

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**C Cleary**



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**Conference on the Enhanced Safety of Vehicles** ,1998      **An Accidental History of Canada** Megan J. Davies,Geoffrey L. Hudson,2024-07-15 Although Canadian history has no shortage of stories about disasters and accidents the phenomena of risk upset and misfortune have been largely overlooked by historians Disasters get their due but not so the smaller scale accident where fate is more intimate Yet such events often have a vivid afterlife in the communities where they happen and the way in which they are explained and remembered has significant social cultural and political meaning An Accidental History of Canada brings together original studies of an intriguing range of accidents stretching from the 1630s to the 1970s These include workplace domestic childhood and leisure accidents in colonial Indigenous rural and urban settings Whether arising from colonial power relations urban dangers perils in resource extraction or hazardous recreations most accidents occur within circumstances of vulnerability and reveal precarity and inequities not otherwise apparent Contributors to this volume are alert to the intersections of the settler agenda and the elevation of risk that it brings Indigenous and settler ways of understanding accidents are juxtaposed with chapters exploring the links between accidents and the rise of the modern state An Accidental History of Canada makes plain that whether they are interpreted as an intervention by providence a miscalculation an inevitability or the result of observable risk accidents and our responses to them reveal shared values

**Monthly Catalogue, United States Public Documents** ,1980      **Monthly Catalog of United States Government Publications** United States. Superintendent of Documents,1986 February issue includes Appendix entitled Directory of United States Government periodicals and subscription publications September issue includes List of depository libraries June and December issues include semiannual index      **Government Reports Announcements & Index** ,1991

*Monthly Catalog of United States Government Publications* ,2002      *Arthritis and Society* Nortin M. Hadler,Dennis B. Gillings,2013-09-03 Arthritis and Society examines the interaction between the structure of our society and the impact of rheumatic diseases on the lifestyle of those afflicted It has drawn the distinction between the private and public experience of illness in order to produce a comprehensive analysis of the impact of musculoskeletal disease on society This book is organized into three main sections Section 1 analyzes the personal experience of pain of the groups frequently afflicted and discusses the epidemiology and scope of the systemic rheumatic diseases Section 2 views the plight of those suffering from rheumatic disease from a different perspective Section 3 highlights the importance of appropriate care and of establishing a more compassionate society which can help lessen the impact of the disease It also considers the role of rehabilitation This book will be of interest to people dealing with studies on arthritis and other rheumatic disease and also those interested in

understanding the impact on societal structure on healthcare issues  
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