



Workplace Safety & Insurance Board



Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

FAX TO – CINDY PRICE ADJUDICATOR – OD& SBP – FAX 416 344-6600 ---PHONE 1800 465-9646 X 416 344 2618 or 416 344-2618

NEW CLAIM REGISTRATION

INJURED WORKER

LAST NAME:

GIVEN NAME:

OCCUPATION:

SIN #

DATE OF BIRTH:

DETAILS OF CONDITION BEING CLAIMED AS WORK RELATED

ADDRESS:

STREET

CITY/TOWN:

POSTAL CODE:

TELEPHONE NUMBER:

ACCIDENT EMPLOYER

NAME:

DATE OF HIRE:

POSITIONS HELD:

DATE OF RETIREMENT:

By signing below, I am claiming benefits under the Workplace Safety and Insurance Board (WSIB) Act, 1997 for a work related injury or disease. I consent to the collection of all information relating to this claim by the Board.

IF YOU CHOOSE A REPRESENTATIVE

I authorize _____ to represent me in my dealings with the Workplace Safety and Insurance Board.

Signature - Date