Policy & Procedure Manual

W.S.I.B. CLAIMS AND FOLLOW UP - HR-X-1

POLICY:

The Coordinator, Health and Safety/Designate of the Human Resources department will establish and maintain a claim file for each employee who sustains a workplace injury resulting in a medical aid/loss of earnings claim.

All records relating to W.S.I.B. claims will be kept for a period of 20 years after the last entry or 40 years after the 1st entry, whichever is the later.

PURPOSE:

1. To ensure consistency and accurate record keeping when establishing W.S.I.B. claims.

2. To ensure compliance with the Workplace Safety and Insurance Act.

PROCEDURE:

1. When an incident occurs, the Coordinator, Health and Safety/Designate will ensure that the immediate or On-Call Supervisor gathers the facts on an Employee Incident Report Form and receives the report in a timely manner.

2. The Coordinator, Health and Safety/Designate will review the Employee Incident Report and investigate further as it is required (see Appendix A). The Coordinator may involve the area representative to provide input into the investigation and for prevention.

3. **Incidents Involving Healthcare and/or Lost Time:**

   The Coordinator, Health and Safety/Designate will:

   i. Work with the Supervisor to offer early and safe return to work, following Policy HR-X-3

   ii. Establish and maintain individual claim files containing the following information:

- Incident report
- W.S.I.B. Data Sheet
- Form 7 – Employer's Report of Injury/Disease
- Form 8 - page 2 only
- FAF – Functional Abilities Form(s), as required
- All relevant claim correspondence/information

ii. Complete the W.S.I.B. Form 7 and fax it to the W.S.I.B. office in Toronto or submit it online, within three days of learning of an occupational injury or disease that disables a worker from working or results in the worker seeking medical attention. See Appendix B.

A copy of Form 7 will be kept in the employee's W.S.I.B. Claim file and a copy will be sent to the employee.

iii. Complete and submit notifications as per policy HR-X-2.

iv. Advise the Human Resources staff, Supervisor, payroll and IT specialist and scheduling staff of W.S.I.B. claims involving lost time and/or modified work, including the accident date.

v. Await claim approval/non-approval from W.S.I.B. and if approved, record the claim number in the claim file.

vi. Communicate with the injured employee. Employees must keep the Coordinator Health & Safety/Designate informed re: next doctor's appointment and any treatment received and recovery process. The employee must keep in touch at least every 10 days or as otherwise established, and produce medical updates on the Functional Abilities form, as requested.

vii. Record all incoming/outgoing phone calls (with employees, practitioners, WSIB, etc.) on the W.S.I.B. Data Sheet. See Appendix C.

viii. When the employee returns to work with a Functional Abilities Form (FAF) for entry into an Early and Safe Return to Work Program, or to full duties, send a copy of the FAF to the W.S.I.B. Keep a copy of each completed form for the files.

ix. Advise the employee as noted above in (iv) of the employee's return to work date and whether the employee returned to regular or modified duties.

When Worker Returns to Regular Duties and Claim is Closed:

The Health and Safety Coordinator/Designate will notify W.S.I.B. in writing. The information on the claim is removed from the current files in the W.S.I.B. binder and filed in a separate file.

RECOMMENDED BY: Manager, Human Resources **APPENDICES:** 3

OPERATIONAL ACCOUNTABILITY: Administration, Human Resources, Supportive Living Services Administration

ORIGINAL POLICY DATE: January 1994

AUTHORIZED BY: Executive Director **SIGNATURE:** 

OPTIONS NORTHWEST
Health and Safety
Incident/Accident Investigation Report

Start Date of Investigation: _____ Completion Date: _____

Investigator(s): _____

What is being investigated?

Incident Report

Date and time of Incident: _____

Location of Incident: _____

Date Incident reported: _____

OR

Inspection Report indicating a Hazardous Situation: _____

Date of Inspection Report: _____

Interviews conducted:

Yes_____ see attached

NO_____Reason:_____

Review the incident report or inspection report, as appropriate and develop questions for those involved to ensure the who, what, when, where, why and how of the incident/hazardous situation have been answered. Record information gathered from each interview on a separate sheet and attach to this report.

Site visit completed? Yes_____ No_____

Comments: _____

If Yes, state details of site investigation. I.e.: confirm that information in incident report is correct, note discrepancies, new/missing information, measurements, weights of objects involved, etc.

Diagrams attached: Yes____ NO____

Pictures attached: Yes____ NO____

OPTIONS NORTHWEST

Health and Safety

Accident/Incident Investigation Interview

Date and time of Incident: _____

Location of Incident: _____

Name of individual being interviewed: _____

Date of interview: _____

Interview Notes:

Investigation Outcome (including recommendations for prevention):

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Mail To: 200 Front Street West Toronto ON M5V 3J1
OR Fax To: 416-344-4684 OR 1-888-313-7373

Please PRINT in black ink

7 Employer's Report of Injury/Disease (Form 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

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

Last Name | First Name

Address (number, street, apt., suite, unit)

City/Town | Province | Postal Code

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

Telephone

Sex ☐ M ☐ F

Date of Hire dd mm yy

Fold here for #10 envelope

B. Employer Information

Trade and Legal Name (if different provide both)

Check one: ☐ Firm Number OR ☐ Account Number | Provide Number

Mailing Address

Rate Group Number

Classification Unit Code

City/Town | Province | Postal Code | Telephone

Description of Business Activity

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 ☐ AM ☐ PM

Date and hour reported to employer dd mm yy ☐ AM ☐ PM

2. Who was the accident/illness reported to? (Name & Position)

Telephone | 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 ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm — Right ☐
- Left ☐ Wrist ☐ Hand ☐ Finger(s) — Right ☐
- Left ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg — Right ☐
- Left ☐ Ankle ☐ Foot ☐ Toe(s) — Right ☐

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.**

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

Claim Number

Please PRINT in black ink

Worker Name | Social Insurance Number

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

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.

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

Claim Number

Please PRINT in black ink

Worker Name | Social Insurance Number

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** 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) | Official title

Signature | Telephone Ext. | Date dd mm yy

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

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

Claim Number

Please PRINT in black ink

Worker Name

Social Insurance Number

K. Additional Information

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

OPTIONS NORTHWEST
HEALTH & SAFETY
WORKPLACE SAFETY AND INSURANCE BOARD DATA SHEET

EMPLOYEE DATA	INJURY/ILLNESS DATA
NAME: _____	TYPE OF INJURY/ILLNESS: _____
ADDRESS: _____	INJURY/ILLNESS DATE: _____
TELEPHONE: _____	LAST DAY WORKED: _____
S.I.N.: _____ AGE: _____	WSIB NO: _____
FAMILY PHYSICIAN: _____	CLAIMS ADJUDICATOR: _____
TELEPHONE: _____	TELEPHONE: _____
SPECIALIST: _____	DATE RETURNED TO WORK: _____
TELEPHONE: _____	TYPE OF WORK: ☐ REGULAR
PRIMARY WORK AREA: _____	☐ MODIFIED

DATE	COMMENTS	SIGNATURE/ DESIGNATION

HS080/MAR 2011

DATE	COMMENTS	SIGNATURE/ DESIGNATION

DATE	COMMENTS	SIGNATURE/ DESIGNATION

DATE	COMMENTS	SIGNATURE/ DESIGNATION