OSSTF WORKPLACE SAFETY AND INSURANCE BOARD FACT REPORTING FORM

Your (Worker's) Name: _____ Home Tel. #: _____

Worker's Address: _____

_____

SIN #: _____ Date of Birth: _____

Accident Date: _____ WSIB Claim #: _____

**On paper, thoroughly describe what caused your accident for your records

Family Doctor's Name:_____ Tel. Contact #:_____

Address: _____

_____

Name of Union Rep: _____ Contact #: _____

Specialist Name:_____ Contact #: _____

Address: _____

_____

Specialist Name:_____ Contact #: _____

Address: _____

_____

Specialist Name:_____ Contact #: _____

Address: _____

_____

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Address: _____

_____

Note Contacts you have had related to your injury Page 2…….

Who contacted you (who did you contact)?: _____

Date:_____ Time:_____ Tel#:_____

Describe what was discussed

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