

**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: \_\_\_\_\_

\_\_\_\_\_

Specialist Name: \_\_\_\_\_ Contact #: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Who contacted you (who did you contact)?: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Tel#: \_\_\_\_\_

Describe what was discussed

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