WORKPLACE SAFETY AND INSURANCE BOARD (W.S.I.B.) Entry Form File#: _____

Legal Name: _____ Date: _____

Claim #: _____ Adjudicator Telephone: _____

Adjudicator Name: _____ Adjudicator Fax: _____

D.O.B. (e.g. 01-Jan-2000): _____ S.I.N. _____ Sex: M / F

Health Card Number: _____ Version Code: _____ Expiry Date: _____

Home Telephone: _____ Work Telephone: _____

Address (No., Street, Apt.): _____ City: _____ Province: _____ Postal Code: _____

EMPLOYER'S NAME: _____

Address: _____ Postal Code: _____

Length of Employment (Months & Years): _____

Job Title/Occupation: _____ Supervisor / Contact Name: _____

Supervisor / Contact Telephone: _____ Ext: _____

Date of Accident: _____ **Time:** _____

Description of Accident - _____

_____

_____

_____

_____

Description of Complaint (Where is problem? What are you feeling/ experiencing?) - _____

_____

_____

_____

_____

Pre-existing conditions or factors that may impact recovery: _____

Current Employment Status:

☐ Full-Time ☐ Part-time / ☐ Regular hours ☐ Modified hours / ☐ Regular duties ☐ Modified duties

Any time missed? (dates): _____

_____

IF FOR ANY REASON YOUR CLAIM IS NOT ACCEPTED OR IS DISCONTINUED, YOU ARE RESPONSIBLE FOR ALL CHARGES.

_____ _____

Signature **Date**

Mount Forest Chiropractic - 148 Main Street South - Mount Forest, ON N0G 2L0

Michelle A. Gross, B.Sc.(Hons), D.C. G. Murray Townsend, B.Sc., D.C. Brianne O'Driscoll, B.Sc., D.C.