WSIB FORM 6 AND FUNCTIONAL ABILITIES FORM

INSTRUCTIONS FOR COMPLETION

If you are using this 9 (nine) page package, you have sustained a workplace injury in the course of duty that requires medical assessment/treatment. You are required to complete these forms in order to establish a claim with WSIB and receive benefits to assist in your recovery.

Completing an Employee Incident Report (EIR) does NOT establish a WSIB claim for a workplace injury !!!

This package contains the following WSIB Forms:

- **Form 6 – Worker's Report of Injury/Disease (4 pgs)**
  - To be completed by you as soon as possible after your injury.
- **Functional Abilities Form for Planning Early and Safe Return to Work Form (FAF) (4 pgs)**
  - To be completed by your attending Healthcare Professional

Once the forms are complete:

1. Fax both (Form 6 **AND** FAF) to:

   - Disability Management Coordinator: **1-866-604-5311**
   - CUPE 1019 Office: **(905) 680-7946 ***

   *(Optional – only if you would like Union assistance in your claim):

2. Fax the Form 6 to:

   - WSIB : **1-888-313-7373**

If you require any assistance completing the Form 6, please call or email:

Jim Simpson
CUPE 1019 WSIB and Benefits Advisor
Cell: (905) 984-1340 **Email:** 1019wsib@gmail.com

Blaine Bittman
CUPE 1019 Secretary and WSIB Advisor
Cell: (905) 329-4237 **Email:** bittyman@gmail.com

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Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Mail To:
Workplace Safety and Insurance Board
200 Front Street West
Toronto ON M5V 3J1

OR Fax To:
416-344-4684
OR 1-888-313-7373

6 Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in black ink

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A. Worker Information

start >

Last Name	First Name	Social Insurance Number

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

City/Town | Province | Postal Code | Alternate/Cell Phone

Job Title/Occupation (at the time you were hurt) | Date you started with employer dd mm yy | How long have you been doing this job for this employer?

Only check **if** you are one of the following: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer | Date of Birth dd mm yy

Sex ☐ M ☐ F | Your Preferred Language ☐ English ☐ French ☐ Other | Would an interpreter be helpful? ☐ yes ☐ no

Are you a member of a union? ■ yes ☐ no | Do you authorize your union to represent you in this claim? ☐ yes ☐ no | If **yes**, do you consent to the disclosure of verbal claim file status information to your union representative? ☐ yes ☐ no

Provide your Union Name and Local
CANADIAN UNION OF PUBLIC EMPLOYEES - LOCAL 1019

B. Employer Information

Company/Employer Name
REGIONAL MUNICIPALITY OF NIAGARA - PUBLIC HEALTH DIVISION - NIAGARA EMS

Address
1815 SIR ISAAC BROCK WAY

City/Town	Province	Postal Code
THOROLD	ONT	L2V 4T7

Your Immediate Supervisor's Name | Company Telephone 905 984-5050

C. Accident/Illness Dates & 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 did you report this accident/illness to? (Name & Position) | Telephone

3. Area of Injury (Body Part) - **(Please check all that apply)**

☐ Head ☐ Face ☐ Eye(s) ☐ Ear(s)
☐ 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 ☐

☐ Other:

Are you: ☐ Left Handed ☐ Right handed

4. Did the accident/illness happen on the employer's property or work site? ☐ yes ☐ no | Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):

5. Did it happen outside the Province of Ontario? ☐ yes ☐ no | If **yes**, indicate where (city, province/state, country):

6. Have you hurt this area(s) of your body before? ☐ yes ☐ no

7. Do you have any prior related WSIB/WCB claims? ☐ no ☐ yes - In Ontario ☐ yes - Outside Ontario

A guide to complete this form is available at www.wsib.on.ca

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

6 Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in black ink

Worker Name - Last Name	First Name	Social Insurance Number

C. Accident/Illness Dates & Details (continued)

8. If you had a sudden type of accident/illness, describe your injury and what happened to cause it (e.g. hurt lower back while lifting a 50 pound box, sprained left ankle when I slipped on a wet floor, used a new cleaner and immediately got a rash). Please indicate the size, weights and names of any objects involved.
or
If you had a gradual onset type of injury, describe your injury, the work that you do and what you believe caused your injury/condition.

start >

9. When did you first start to have problems with this injury/condition?

10. If you did not report this to your employer right away, please tell us the reason why.

11. If there were any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, give us their names & positions.

Name	Position
1.	
2.	

12. The Workplace Safety and Insurance Act requires your employer to give you a copy of the Employer's Report of Injury/Disease (Form 7).
Did you receive a copy of the Form 7? ☐ yes ☐ no

The Workplace Safety and Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer.

D. Health Care Information

Give your Health Professional your WSIB Claim number.

1. Did you get first aid or care at work ☐ yes ☐ no If **yes**, when dd mm yy and by whom (Name):

2. Where did you go for health care, for your injury, outside of work? **(Check all that apply)**

	Facility/Hospital (Name & Address)	Date of Visit (dd/mm/yy)		Date of Visit (dd/mm/yy)
☐ Nursing Station ☐ Emergency Department ☐ Admitted to Hospital			☐ Ambulance ☐ Health Professional Office ☐ Clinic	

3. Were you prescribed any medications/drugs? ☐ yes ☐ no

4. Were you referred for any other treatment or tests? ☐ yes ☐ no

5. Did you talk to your health professional about going back to regular or modified work? ☐ yes ☐ no If **yes**, were you given any work limitations? ☐ yes ☐ no

6. Did you tell your employer you went for medical treatment? ☐ yes ☐ no **If no, please tell your employer right away.**

If **yes**, when? dd mm yy and to whom? Name Position

next page

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6 Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in black ink

Worker Name - Last Name	First Name	Social Insurance Number

E. Lost Time & Return to Work

1. After the day of accident/illness:

start > ☐ I returned to work to my **regular job** and **did not** lose any time or pay.

☐ I returned to **modified duties** and **did not** lose any time or pay.

☐ I **lost time and/or pay** (e.g. regular pay, shift differential, bonuses, premiums, etc.).

→ Date you first lost time and/or pay — dd mm yy

2. If you lost time, have you returned to work? ☐ yes ☐ no

If **yes** ▶ Date of your return to work — dd mm yy ☐ regular work ☐ modified work

If **no** ▶ Did you discuss return to work with your employer? ☐ yes ☐ no

Does your employer have modified work? ☐ yes ☐ no

F. Earnings (Do not include overtime here)

1. Rate of pay: $ ..... per ☐ hour ☐ week ☐ other: .....

2. Usual number of pay hours: ..... per ☐ week ☐ other: .....

3. If you lost time from work after the day of accident/illness, did your employer continue to pay you? ☐ yes ☐ no

4. Have you applied for, or did you receive, any other benefits (money) while off work (e.g. EI benefits, sick benefits, social services, insurance, etc.). ☐ yes ☐ no

5. At the time of the accident/illness did you work for more than one employer? ☐ yes ☐ no

G. Declarations and Signature

By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the WSIB's "Functional Abilities Form for Planning Early and Safe Return to Work".

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.

Signature	Date (dd/mm/yy)
Please print form & sign before returning to the WSIB	

If you are under the age of 16, your parent or guardian, must authorize the release of the functional abilities information.

Signature	Relationship:	Date (dd/mm/yy)	Telephone
Please print form & sign before returning to the WSIB			( )

Personal information about you will be collected throughout your claim under the authority of the Freedom of Information and Protection of Privacy Act and will be used to administer the Workplace Safety and Insurance Act, 1997, your claim(s) and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, Canada Revenue Agency (CRA), and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax receipts and is collected under the authority of the Income Tax Act. Information may only be disclosed to the employer, external medical, vocational, and safety agencies, external payment and service providers, researchers, and others as authorized by the Workplace Safety and Insurance Act and the Freedom of Information and Protection of Privacy Act. Your name and telephone number may be disclosed to third party researchers conducting satisfaction surveys and focus groups. Incoming and outgoing calls may be recorded for quality assurance purposes. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-0750.

A more detailed PRIVACY STATEMENT for workers may be found at www.wsib.on.ca or by calling toll free at 1-800-387-0750.

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

6 Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in black ink

Worker Name - Last Name	First Name	Social Insurance Number

K. Additional Information

start >

The Workplace Safety & Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer

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Functional Abilities Form

for Planning Early and Safe Return to Work

Health Professionals, please use this form ONLY when requested by an employer or worker.

The purpose of this form is to identify your patient's overall functional abilities and work restrictions that will assist his/her return to suitable work.

Please promptly complete and return pages 2 and 3 of this form to the worker or employer to assist the workplace parties in planning an early and safe return to work.

PLEASE ENSURE YOUR BILLING INFORMATION IS NOT GIVEN TO THE WORKER OR EMPLOYER.

Authority to Release Information

Section 37(3) of the *Workplace Safety and Insurance Act, 1997* provides the legal authority for health professionals to give the Workplace Safety and Insurance Board (WSIB), the injured worker and the employer such information as may be prescribed concerning the worker's functional abilities.

When completing this report, please **print** in **black ink**.

Worker and/or employer should complete Sections A and B of this report. If your patient needs assistance, please help. Please submit this report even if Section A is not fully completed.

Information about your responsibilities can be found on **Page 4**.

The WSIB will pay health professionals for completing this form.

Mail to:
Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

OR

Fax to:
416-344-4684
or 1-888-313-7373

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A guide to completing this form is available at www.wsib.on.ca

print

WSIB ONTARIO CSPAAT

Mail to:
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or Fax to:
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OR 1-888-313-7373

Please PRINT in black ink

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FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

start

Claim No.

A. Section A to be completed by the employer and/or worker.

Worker's Last Name	First Name	Telephone

Address (no., street, apt.)	City/Town	Province	Postal Code

Employer's Name	Date of Birth (dd/mm/yyyy)
Full Address (No., Street, Apt.)	Date of Accident/ Awareness of Illness (dd/mm/yyyy)
City/Town / Prov. / Postal Code	Employer Telephone
	Employer Fax No.

fold

1. Type of job at time of accident (where available, please attach description of job activities)	Area(s) of injury(ies)/illness(es)
2. Have the worker and the employer discussed Return To Work ☐ yes ☐ no	If no, will be discussed on dd mm yyyy
3. Employer contact name	Position

fold

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature	Date dd mm yyyy
Please print form & sign before returning to the WSIB	

C. Health Professional's Billing Information
For billing purposes fax or mail pages 2 and 3 to the WSIB.

Health Professional's Designation
☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other

PROVIDER BILLING INFORMATION IN THE BOLDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

Are you registered with the WSIB?
☐ yes Please enter the **WSIB Provider ID.** in the box provided
☐ no Please call **1 - 800-569-7919** to register

WSIB Provider ID.

Health Professional's Name (please print)	**Your Invoice Number**
Address (No. Street, Apt.)	Service Code **FAF**

City/Town	Province	Postal Code	Fax

I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature	Telephone	Date dd mm yyyy
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Mail to:
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Toronto ON M5V 3J1

or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Worker's Last Name	First Name	Claim No.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment dd mm yyyy

start

2. Please check one:

- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

Travel to work:
- Ability to use public transit: ☐ yes ☐ no
- Ability to drive a car: ☐ yes ☐ no

2. Please indicate **Restrictions** that apply. Include additional details in section 3

- ☐ Bending/twisting repetitive movement of (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environmental exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s):
  - Left: ☐ Gripping ☐ Pinching ☐ Other (please specify)
  - Right: ☐ ☐ ☐
- ☐ Limited pushing/pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify) Do not include names of medications.
- ☐ Exposure to vibration:
  - ☐ Whole body
  - ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions**.

4. From the date of this assessment, the above will apply for approximately:
☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ yes ☐ no

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours

Start Date dd mm yyyy

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions**. dd mm yyyy

I have provided this completed Functional Abilities Form to: ☐ **Worker** **and/or** ☐ **Employer**

Important Information

To receive benefits, the worker must apply for benefits within six months of the date of a work-related injury or illness. When filing a claim for benefits, the worker must also consent to the disclosure of functional abilities information provided by a health professional to his or her employer for the purpose of facilitating an early and safe return to work. Failure to file a claim or provide consent for the release of the functional abilities information can result in no benefits.

If you have questions about the completion of this form please call 1-800-387-0750.

Worker's Responsibilities

- This form is to be completed by a treating health professional, who will discuss the information with you.
- Once completed, contact your employer **immediately** to review the information on the completed form. Together, you and your employer will begin to plan an early and safe return to work.

Employer's Responsibilities

- This form provides general information about this worker's functional abilities and restrictions to help you plan an early and safe return to work.
- When you provide this form to the treating health professional, ensure that you have the worker's signed consent (Section B) for the release of functional abilities information.
- Where available, also attach a description of the worker's job activities to assist the health professional in completing the form.
- The prescribed form that is available from the WSIB is a generic form developed to assist with general functional abilities information.
- The WSIB will pay the health professional to complete the prescribed WSIB form only. A charge will appear on your Accident Cost statement or Schedule 2 Invoice which reflects the cost of payment for each form completed.
- If you have a form that is specific to your workplace and have the cooperation of the worker in providing consent for the release of information on your form, you may use your own form. If you create your own form, you must reimburse the health professional directly.
- Do not send a copy of the completed Functional Abilities Form for Planning Early and Safe Return to Work to the WSIB. The health professional is responsible for submission of the form.

Health Professional's Responsibilities

- The employer and worker will use this information to plan the worker's early and safe return to work.
- Their return to work plans will reflect the functional abilities and restrictions you have noted and presume that no clinical contraindications exist for other work activities, therefore it is crucial that all sections be completed in full.
- The completion of this form is based on your examination of the worker and does not require a specialized functional abilities evaluation.
- Diagnostic or confidential information **must not** be included.
- Please add specific information on the duration of temporary restrictions or maximum times or weights to be considered, in section **E3** under **abilities and/or restrictions**. If necessary, attach an additional page to this completed form to describe abilities and restrictions.
- **Completion of this form does not replace clinical reporting requirements to the WSIB** .
- **Once you have received this form, promptly complete it and give it to the worker and/or employer.**
- **For billing purposes fax or mail pages 2 and 3 to the WSIB. When faxing, do not mail a copy.**

The WSIB will pay the health professional for the completed form when pages 2 and 3 are received.

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200 Front Street West
Toronto ON M5V 3J1

WSIB Fax 416-344-4684
or 1-888-313-7373

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revised march 08