Dr. John Ahokas 26 Fead Street, Orangeville, ON L9W 1A8 (519) 941-2311

W.S.I.B. FORM

Name:_____

Home Telephone: _____ Business Telephone: _____

Date of Birth: _____ WSIB Claim #:_____

Adjudicator: _____ Adjudicator's Telephone: _____

Job Title/Occupation: _____

Employer's Name: _____

Address: _____ Postal Code: _____

Telephone: _____ Contact Name at work place: _____

Date of Accident: _____ Time: _____

Referred by: _____

Did you inform your employer about the injury? Y N When: _____

Have you seen another Health Care provider? Y N If yes, please fill in the following:

Name of Provider_____ Date_____

Location _____

DESCRIPTION OF ACCIDENT: _____

_____

_____

_____

_____

_____

IF FOR ANY REASON W.C.B WILL NOT ACCEPT YOUR CLAIM, YOU ARE RESPONSIBLE FOR ALL CHARGES.

_____ _____

Signature Date