WSIB

MADISON CHIROPRACTIC CLINIC – DR. MICHAEL RODNEY

IF YOUR INJURY OCCURRED AT WORK, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

DATE OF INJURY:________________ **TIME:** ___________________ AM PM
WHERE DID THIS INJURY OCCUR? AT WORK OTHER: ______________________________
NAME OF EMPLOYER: ______________________________
ADDRESS: ______________________________ **POSTAL CODE:** ____________________
PHONE #: ___________________ **FAX #:** ____________________ **CONTACT NAME AT WORK PLACE:** ____________________
SOCIAL INSURANCE NUMBER: ______________________________

HAVE YOU REPORTED THE ACCIDENT TO YOUR EMPLOYER YET? NO YES
WSIB CLAIM # (If known): ______________________
NAME OF ADJUDICATOR/NURSE CASE MANAGER ASSIGNED TO YOU? (If known): ______________________
PHONE #: ____________________________ **FAX #:** ____________________________

PLEASE DESCRIBE WHAT HAPPENED: ______________________________
____
____
____
____
____
____
____

WAS THIS INJURY CAUSED BY LIFTING AN OBJECT? NO YES:
ABOVE HEAD WAIST LEVEL BENDING TWISTING HEAVY LOAD
WAS THIS INJURY CAUSED BY A FALL? NO YES:
STAIRS CARRYING LOAD OBSTACLE INVOLVED AWKWARD POSITION ICE GREASE WETNESS
WAS THIS INJURY CAUSED BY OVERUSE? NO YES:
WHAT LIMITATIONS HAVE YOU NOTICED SINCE THE ACCIDENT?

CAN'T WORK	CAN'T LIFT	OTHER: ______________________
CAN'T WORK ON COMPUTER	CAN'T BEND	OTHER: ______________________
CAN'T SIT FOR LONG	CAN'T CONCENTRATE	OTHER: ______________________
CAN'T DO REPETITIVE MOTIONS	CAN'T STAND FOR LONG	OTHER: ______________________

HAVE YOU LOST ANY DAYS FROM WORK? NO YES: List Dates: ______________________
DO YOU HAVE AN ATTORNEY WHO HAS ADVISED YOU IN THIS CASE? NO YES: Name: _______________ Phone #: _______________
HAVE YOU SEEN ANY OTHER HEALTH PROFESSIONAL FOR THIS INJURY? NO YES: Who? ______________________
Phone #: ______________________________
DID THEY FILL OUT ANY WSIB FORMS NO YES

PLEASE READ AND SIGN THE FOLLOWING:
The above statements are true to the best of my knowledge.
If for any reason WSIB will not accept or discontinue my claim, I am responsible for all charges.

Signature: ____________________________ **Date:** ______________________________