



WORKERS SAFETY INSURANCE BOARD INFORMATION FORM

**The following information is required to
arrange direct billing to the WSIB.*



First Name: _____ Last Name: _____

Date of Birth: _____

Home Address: _____ Suite/Apt: _____

City: _____ Province: _____ Postal Code: _____

Home Phone #: _____ Work/Cell #: _____

Referring Doctor: _____

Diagnosis/Injury: _____

Date of Injury: _____

Claim #: _____

Has this injury been reported to your workplace? Yes No

Are you currently off work as a result of this injury? Yes No

Employer's Name: _____

Employer's Address: _____

City: _____ Province: _____ Postal Code: _____

Employer's Phone #: _____

Occupation/Job Title: _____

Health Card #: _____

Social Insurance #: _____

WSIB Adjudicator Name: _____

WSIB Adjudicator Phone #: _____

Additional Information: _____

If you have any questions – please call. Once this form is completed – **FAX** it to us or bring it in to one of our 2 clinic locations. Completing this form in advance greatly assists us in arranging your billing with WSIB. Please note that we will be contacting WSIB to check on the status of your claim prior to arranging your appointments. Thank-you.

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