

GUIDELINES FOR STUDENTS ON UNPAID WORK PLACEMENTS

These are guidelines prepared by the Colleges and Universities Branches of the Ministry of Training Colleges and Universities to assist in the understanding and administration of workplace insurance for students on unpaid work placements. The complete WSIB Operational Policy Manual can be found on line at www.wsib.on.ca.

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I. INTRODUCTION

In 1992, the Workers' Compensation Board, now the Workplace Safety and Insurance Board (WSIB), initiated a policy review of workers' compensation coverage for learners on unpaid work experiences, with a view to ensure a uniform approach for learners and to create a favourable training environment in the province. Interim guidelines were established in August of 1992 to cover the period September to December 1992, later extended to June 1993.

In February 1993, the Ministry of Labour announced that the Ontario government would fund the workers' compensation costs of learners injured while on unpaid placement.

The Workers' Compensation Board issued a policy for providing workers' compensation coverage for learners on unpaid work placements in July 1993.

WSIB benefits for learners injured in on-the-job accidents include health and medical costs, temporary and long-term disability coverage, and rehabilitation and survivors' benefits.

The following guidelines and mandatory requirements apply to all accidents occurring to college or university "learners" on unpaid placements occurring on or after July 1, 1993.

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II. STATUTORY AND REGULATION FRAMEWORK DEFINITIONS

The complete WSIB Operational Policy Manual can be found on line at www.wsib.on.ca.
Relevant documents include:

Individuals on Unpaid Training Placements	12 - 04 - 04
Who is an Employer?	12 - 01 - 01
Non-Resident Workers	12 - 04 - 12

Part 1, Section 2. (1) of the *Workplace Safety and Insurance Act, 1997* includes the definition of a worker:

a person who has entered into or is employed under a contract of service or apprenticeship and includes the following:

learner.

Part 1, Section 2. (1) of the *Workplace Safety and Insurance Act, 1997* defines a learner as:

a person who, although not under a contract of service or apprenticeship becomes subject to the hazards of an industry for the purpose of undergoing training or probationary work;...

Part 1, Section 2. (1) of the *Workplace Safety and Insurance Act, 1997* outlines that the definition of “employer” includes:

every person having in his, her or its service under a contract of service or apprenticeship another person engaged in work in or about an industry and includes, ...

(b) a person who authorizes or permits a learner to be in or about an industry for the purpose of undergoing training or probationary work, ...

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III. WORKERS' COMPENSATION BOARD POLICY GUIDELINES

Workers' Compensation Board policy establishes that "Individuals who are placed by training agencies with employers to obtain work skills and experience, but who are not paid by the employer, are "learners". The "employer" of these individuals is the employer with whom they are placed."

The following guideline applies only to training participants who are not paid by the placement employer. The following are not considered payment for the purpose of this policy:

- social assistance benefits (e.g. welfare)
- training allowances
- honoraria
- reimbursement of expenses
- stipends or any money paid to the training participants by the training agency, e.g. FUTURES

General Principles

1. Individuals on unpaid training placements with employers are "learners" if both of the following conditions are met:
 - The placement is authorized by a postsecondary institution or training agency, and
 - The individual participates, however minimally, in the activities of the placement employer's industry.

Participating in the activities of the workplace includes job shadowing/twinning.

2. Learners under this policy include:
 - a. College or university students on a training placement with an employer as a formal part of their course or program. Examples are:
 - nursing students on placement with a hospital
 - law and security students on a placement with a police force
 - social work students on a placement with a social service agency

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- b. Ontario residents enrolled in an out-of-province training program, who do the placement portion of the program with an Ontario employer covered by the *Act*.
 - c. Non-Ontario residents enrolled in an out-of-province training program, who do the placement portion of their program in Ontario with an employer covered under the *Act* (subject to the provisions of the WSIB Operational Policy Number 12-04-12, see www.wsib.on.ca for all relevant WSIB Operational Policies)
3. The following individuals on unpaid placements are not learners under this policy:
- a. Individuals who on their own initiative volunteer their services to an employer to develop marketable work skills.
 - b. Volunteers who offer their time or services for community or charitable purposes.
 - c. Individuals in health care or correctional institutions who perform unpaid work as a component of therapy or correction.
 - d. Individuals placed with an employer under a Community Service Order issued by a court of law
 - e. Individuals who are on the employer's premises solely for the purposes of visiting or casual observation and who at no time participate in the activities of the employer's industry.
 - f. University and college students who as part of their program do unpaid research for the college or university.
 - g. Individuals who are not on placement but as part of the training program perform work on the training agency's premises (such as students on a weekly practicum).
 - h. Ontario residents in an Ontario training program who do the placement portion of their program with an out-of-province employer.

Special Situation Covered by this policy

- Placement employer with no workers

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If an operator in an industry covered by the *Workplace Safety and Insurance Act, 1997* normally employs no workers, but becomes an employer solely by virtue of taking on a learner, the employer and the learner are protected under the *Act*.

Under these circumstances, no penalty is levied on the employer for not registering with the Board.

Situations that are not covered under this policy include:

1. Laid-off apprentices, who continue to train through an unpaid placement with an employer, are not learners under this policy. These individuals are “apprentices” (see WSIB Operational Policy number 01-02-08, see Appendix A for all relevant WSIB Operational Policies)
2. Workers’ compensation coverage extends only to the job placement portion of the training program. There is no workers’ compensation coverage for in-class portion of training programs.
3. Placement employer not covered by the *Workplace Safety and Insurance Act, 1997*. There is no workers’ compensation coverage if a learner is placed with an employer that is not mandatorily covered under the *Act* and that has not obtained coverage by application to the Ministry of Education. (Please see page 13 regarding private insurance coverage.)

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IV. MANDATORY REQUIREMENTS

Funding for Workers' Compensation Coverage by the Provincial Government

Learners eligible to receive full funding for Workers' Compensation coverage by the provincial government must meet all of the following criteria:

- a learner is "unpaid" as defined by the WSIB policy and meets the definition of "learner" under the *Workplace Safety and Insurance Act, 1997*;
- the learner must be placed with an employer covered by the *Workplace Safety and Insurance Act, 1997*;
- unpaid learners take work placements as part of a training/educational program funded or subsidized by the Ontario government; and
- work placements are authorized by or under the auspices of a government recognized training agency (e.g. college or university) or government ministry.

Visa and out-of-province students enrolled in colleges and universities are included under the policy.

The Ministry of Education has established a confidential, unique WSIB firm number for each college and university within the postsecondary education sector in Ontario. Firm numbers are used to identify an institution and track claim charges to the ministry.

Safety for Learners

It is the responsibility of the college or university to provide training in safe working practices as part of the educational/training program. The workplace employer should reinforce the need for such practices and ensure that the working environment provides opportunity for the learner to work in a safe manner without undue exposure to risk.

When arranging work placements for learners, some evaluation of the safety practices of the potential employer should be done. Learners should not be placed in unsafe working environments.

Work/Education Placement Agreement/Postsecondary Form

The college or university, learner and employer concerned must make an agreement before the learner begins the work placement training or attends the workplace

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employer's premises. This ensures that all parties in work placement situations understand the coverage available to unpaid learners.

The Work/Education Placement Agreement forms (see Appendix A) provided by the ministry must be completed for postsecondary and tuition-short learners involved in an unpaid work experience to be eligible to be covered under the province's funding for workers compensation coverage for learners on unpaid work placements. These forms are not to be used with Laid-off Apprentices.

On the form for individual learners, the participant's signature must appear, indicating consent to conditions of coverage in the agreement. If the learner is under the age of majority, the consent of a parent or guardian is necessary.

If using the form for multiple learners an addendum to the agreement must include the following:

- a. the local address and telephone number of each learner,
- b. the specific days and hours when each learner will be at the employer's workplace, and
- c. the consent of each learner to the conditions of coverage specified in the Work/Education Placement Agreement form.

If the employer is covered under the *Workplace Safety and Insurance Act, 1997*, complete Section C of the form.

If the employer is not covered under the *Workplace Safety and Insurance Act, 1997*, complete Section D of the form. Private insurance will be provided by the Ministry of Training, Colleges and Universities.

A form for each learner on an unpaid work experience should be completed and remain on file in the college or university for use in the event of an accident. The form should be retained for one year after the learner completes the program.

Additional forms

The Work Educational Placement Agreement/Post secondary form can be found online at: <http://www.edu.gov.on.ca/eng/document/forms/631352.pdf>

They can also be ordered in bulk by emailing your request to eduservice@ppfd.ca. Please ask for form number 63-1352.

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V. REPORTING PROCEDURES AND CLAIMS

Any injury, however minor, to a learner in a work experience, should be reported by the learner to the employer and to the appropriate contact person in the educational institution or training agency. Information must include when, where, and how the injury occurred. Accidents requiring only first-aid do not have to be reported to the WSIB but a record of the details should be kept by the educational institute or training agency in the event that a report is required in the future.

When to report an accident to the Board

A completed WSIB Form 7 “Employer’s Report of Injury/Disease” (see Appendix B) must be completed by the employer within three days of learning of a work-related accident and the form must be submitted by the educational institution or training agency to the Board within seven days of learning of a work-related accident. This obligation exists when an accident results in injury to the learner that requires:

1. health care by a medical practitioner for which there is a fee for service (this could include a physician, dentist, chiropractor, hospital, etc.) and/or
2. lost time from work beyond the date of the accident, or
3. exposure to communicable disease.

Instructions and Guidelines for Completing the Form 7 are included with the Form on the WSIB website. Attention to detail at the time of reporting helps eliminate later difficulties and unnecessary delays resulting from the Board’s need to request routine information. A copy of Form 7 and the Instructions and Guidelines can be found in Appendix C.

Form 7 and support documentation can also be found at the following Url:

[http://www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/DownloadableFileReportofInjuryForm7/\\$File/Form7.pdf](http://www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/DownloadableFileReportofInjuryForm7/$File/Form7.pdf)

All colleges and universities have been assigned a unique firm number to be used in all correspondence with the WSIB. Completion of the Form 7 is the joint responsibility of the workplace employer and the college. Under the *Workplace Safety and Insurance Act, 1997*, the workplace employer is considered to be the “employer” for the learner. As such, the employer must authorize the colleges or university to act as his/her representative with the Workplace Safety and Insurance Board regarding the claim being submitted. A “Letter of Authorization to Represent the Placement Employer” has

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been prepared and may be copied (see Appendix C). A completed copy of this form must be attached to the Form 7.

After filling out Form 7, please print it, sign it and send a copy to the WSIB along with the Employer's Authorization and the Work/Education Placement Agreement for the learner involved in the accident. Keep a copy for your records.

All subsequent communication from WSIB will then flow to the college or university.

Copies of the Form 7 should also be provided to the injured learner, and the Ministry of Training, Colleges and Universities.

For claims involving colleges send copies to:

Colleges Branch
Ministry of Training, Colleges and Universities
9th Floor Mowat Block
900 Bay Street
Toronto, ON
M7A 1L2

Fax: (416) 325-2245

Contact: Cheryl Clarke (416) 314-7700

For claims involving universities send copies to:

Universities Branch
Ministry of Training, Colleges and Universities
7th Floor Mowat Block
900 Bay Street
Toronto, ON
M7A 1L2

Fax: (416) 325- 1959

Contact: Heather Schramm (416) 325-8925

Penalties for late filing

The completed Form 7 along with the letter of authorization and the Work/Education Placement agreement must be completed by the employer within three days of learning

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of the work related accident and the form must be submitted by the college or university to the Board within seven days of learning of the work-related accident. There is a \$250 penalty for late submission, incomplete information, not reporting on a pre-approved version of this form, and/or failing to provide a copy of the completed Form 7 to the learner.

Colleges and universities should not delay submitting Form 7's while waiting for more detailed information. For example, if statements from witnesses are not finalized or available by the deadline date for submission, incomplete reports may be filed to comply with the seven-day requirement. Additional pertinent information can be forwarded in a letter as soon as possible after the accident.

If a delay does arise and can be justified explain the circumstances in a letter to the Board. The Board may choose to waive the late fee.

The completed Form 7 can be sent/filed with the Board by facsimile to ensure the time limit is met. A hard copy of the Form 7 must be sent by mail to the Board as follow-up (unless the original is couriered to the Board within the timelines).

Action Following the Filing of a Claim

Following submission of the claim, WSIB will determine whether the injury or disease is work-related and whether benefits should be paid to the injured learner. Once a claim is approved, the injured learner will remain on Workers' Compensation until the learner has recovered to the point where he or she can return to the training program. The learner may still be in receipt of benefits after he or she returns to the program, if there is any ongoing impairment. Any benefit entitlement paid out by the Board to unpaid learners as a result of claims submitted utilizing the firm numbers assigned to postsecondary institutions through the Ministry of Education will subsequently be charged to the Ministry of Training, Colleges and Universities. The Ministry of Training, Colleges and Universities will pay such invoices centrally on behalf of the colleges.

All communications regarding the claim will be forwarded to the identified contact in the college or university as per usual WSIB processes if the workplace employer's authorization is attached to the Form 7. The college or university assumes the role of the employer for the learner's claim. Once entitlements have been granted, it is important that a designated individual within the college or university contact the Board on a regular basis. After a claim is allowed, the Board periodically requires information to confirm continuing entitlement to benefits. Copies of these forms are included in Appendix B. Details on their use are available from the WSIB.

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The learner or the college or university, as the authorized agent of the placement employer, can appeal any decision made by the WSIB. Information on the appeal process is available from the WSIB.

For information on the completion of other WSIB forms and a more complete description of WSIB processes, reference should be made to the WSIB Operational Policy Manual. This manual is available from the Board as a subscription or online at www.wsib.on.ca.

Managing Workers' Compensation Claims

The college or university is required to maintain contact with all parties involved throughout the duration of a claim, including the WSIB, the injured learner and his/her physician, and the workplace employer. The goal should be to minimize the impact of the accident on the learner through an early return to the training program. Some modification of the training program and/or the workplace experience may be necessary to accommodate the learner if there are ongoing limitations.

Responsibilities

It is the responsibility of the training agency to ensure the mandatory paperwork is completed and appropriately disseminated in a timely manner before an unpaid work placement begins and in the unfortunate case of a learner being injured while on the unpaid work placement

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VI. Private Insurance and Data Collection

Private insurance coverage will be provided for learners from Ontario institutions in the event that the work placement employer is not covered by the WSIB. The Ministry of Training, Colleges and Universities will provide the private insurance coverage for the entire period.

In this case, the number of work placement hours for which private insurance coverage is needed must be identified to the ministry.

For the purpose of insurance premiums, each year colleges and universities are required to file with the Ministry of Training, Colleges and Universities:

- the total hours of unpaid work placement by program with employers not covered under the *Act* and the total number of students involved. For non-WSIB placements, it will be necessary to indicate the application industry where placement occurs; and
- the funding source for these hours. (For example, Ministry-supported postsecondary students will be reported separately from visa postsecondary students and Job Connect trainees.)

The ministry requires this information by semester and contacts institutions shortly after the end of each semester (January, May and September).

ACE INA Reporting Procedures and Claims

In the event of a workplace accident with a placement employer not covered by WSIB, training participants are provided with Ace INA coverage including benefits for accidental death or injury, and medical/dental benefits to treat an accidental injury.

As with claims involving the WSIB, any injury, however minor, to a learner in a work experience, should be reported by the learner to the employer and to the appropriate contact person in the educational institution or training agency. Information must include when, where, and how the injury occurred. Accidents requiring only first-aid do not have to be reported but a record of the details should be kept by the educational institute or training agency in the event that a report is required in the future.

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To make a claim the training participant must submit a claims form, as well as a proof of loss statement (See Appendix E) to ACE INA. Initial claims must be made within the 30-day period after the accident occurs.

Copies of the claim form, proof of loss statement and the work placement agreement form must also be provided to the Ministry of Training, Colleges and Universities.

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VII. APPENDICIES

Appendices A - D

Name of Form	Where it can be located	Source/ Contact
<u>Appendix A</u>		
Work/Education Placement Agreement/ Postsecondary	http://199.71.28.92/eng/document/forms/631352.pdf Or they can be ordered through PPFD by emailing eduservice@ppfd.com. Please ask for Form number 63-1352.	Ministry of TCU Colleges: Cheryl Clarke (416) 314-7700 Universities: Heather Schramm (416) 325-8925
<u>Appendix B</u>		
Form 7 – Employer’s Report of Injury/Disease	http://www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/DownloadableFileReportofInjuryForm7/\$File/Form7.pdf	Workplace Safety and Insurance Board www.wsib.on.ca
Letter of Authorization to Represent the Placement Employer		Ministry of TCU Colleges: Cheryl Clarke (416) 314-7700 Universities: Heather Schramm (416) 325-8925
<u>Appendix C</u>		
Form 9 - Employer’s Subsequent Statement	http://www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/DownloadableFileForm9/\$File/Form9.pdf	Workplace Safety and Insurance Board www.wsib.on.ca

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Appendix D

ACE INA Insurance Statistics		Ministry of TCU Colleges: Cheryl Clarke (416) 314-7700 Universities: Heather Schramm (416) 325-8925
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Appendix E

ACE INA Insurance Claims Forms		ACE INA Claims Department 1-877-772-7797
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Appendix A

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Ministry of Education /
Ministère de l'Éducation

**Work/Education Placement Agreement/Post-Secondary /
Accord sur la formation pratique (postsecondaire)**

The information on this form is required to maintain the employment record of the training participant and is collected under the authority of the Workplace Safety and Insurance Act, 1997, c.16, s.21, 22; and the Ministry of Colleges and Universities Act, R.S.O. 1990, c.M.19, s.5, and Order-in-Council 701/85. Because the Ministry of Education covers the cost of workers' compensation and private insurance coverage, the Ministry may use this information to verify the legitimacy of claims. Inquiries regarding this form should be directed to the Ministry of Education, 8th Floor, Mowat Block, 900 Bay Street, Toronto, Ontario, M7A 1L2. Telephone (416) 325-2547.

Les renseignements contenus dans ce formulaire sont requis pour tenir à jour le relevé d'emploi de la personne recevant une formation. Ils sont recueillis en vertu des articles 21 et 22 de la Loi de 1997 sur la sécurité professionnelle et l'assurance contre les accidents du travail, de l'article 5 de la Loi sur le ministère des Collèges et Universités, L.R.O. 1990, chap. M.19 et du décret 701/85. Étant donné que le ministère de l'Éducation assume le coût de l'assurance contre les accidents du travail et de l'assurance privée, le ministère peut utiliser ces renseignements pour vérifier la légitimité des demandes. Pour toute question sur ce formulaire, s'adresser au ministère de l'Éducation, 8e étage, édifice Mowat, 900, rue Bay, Toronto ON M7A 1L2, téléphone : (416) 325-2547.

Date Completed / Rempli le

Please print / En caractères d'imprimerie

A. Parties to the Agreement / Parties contractantes

1. Name of training participant / Nom du-de la participant-e à un stage de formation		Date of birth / Date de naissance	Age / Âge	Sex / Sexe
Address / Adresse		Home phone no. / N° de tél. (domicile)	Postal Code / Code postal	
Program / Programme				
2. Name of work placement employer / Nom de l'employeur		Name of training supervisor / Nom du-de la superviseur-e de la formation		
Address / Adresse		Telephone no. / N° de téléphone	Postal Code / Code postal	
3. Post Secondary Institution / Établissement postsecondaire		Name of contact person / Personne-ressource		
Address / Adresse		Telephone no. / N° de téléphone	Postal Code / Code postal	

B. Specific Time at Training Station / Durée du stage et horaire

1. **Period of Agreement / Durée de l'accord**
 The training participant, from / Le-la participant-e au stage de formation devra, du _____ 200_____ to / au _____ 200_____ shall be involved in work activities as part of the above educational/training program as / dans le cadre du programme de formation susmentionné, exécuter les tâches de _____ (job title / désignation de fonction)

2. **Hours of Training / Heures de travail**
 The normal hours of training shall be from / les heures de travail habituelles seront de _____ to / à _____

3. **Schedule of Training / Jours de travail**
 Identify the days when the training participant will be at the work placement (or attach training participant's schedule). / Inscrire les jours où le-la participant-e sera en stage de formation (ou joindre son emploi du temps).
 _____ (days of training / jours de travail)

C. Workplace Safety and Insurance Board Coverage / Assurance de la Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

1. Workplace Safety and Insurance Board coverage will be provided at the work placement by / Les primes de l'assurance de la Commission seront versées par _____ the Ministry of Education / le ministère de l'Éducation for the entire period / pour toute la durée du stage.

2. Number of work placement hours for which Workplace Safety and Insurance Board Coverage has been provided (To be completed after completion of work placement component) / Nombre d'heures en stage de formation pour lesquelles l'assurance de la Commission a été fournie par (remplir une fois le stage terminé).
 By the Ministry of Education / le ministère de l'Éducation 200 _____ 200 _____

D. Private Insurance Coverage / Assurance privée

1. Private insurance coverage will be provided in the event that the work placement employer is not covered by the Workplace Safety and Insurance Board Coverage / Si l'employeur ne bénéficie pas de l'assurance de la Commission, une assurance privée sera retenue par _____ By the Ministry of Education / le ministère de l'Éducation for the entire period /

2. Number of work placement hours for which private insurance has been provided (To be completed after completion of work placement component) / Nombre d'heures en stage de formation pour lesquelles l'assurance privée a été retenue par (remplir une fois le stage terminé).
 By the Ministry of Education / le ministère de l'Éducation 200 _____ 200 _____

E. Signatures of Parties to the Agreement / Signature des parties contractantes

Training participant / Participant-e au stage de formation	Parent/Guardian (if applicable) / Père, mère, tuteur ou tutrice (le cas échéant)
Work placement employer / Employeur	Post-secondary Institution / Établissement postsecondaire

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Appendix B

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Mail to: 200 Front Street West Toronto ON M5V 3J1 FAX: (416) 344-4684 1-888-313-7373

Employer's Report of Injury/Disease Form 7 (Page 1)

Ce formulaire est disponible en français sur demande.

• Please read the instructions on pages 4 & 5

WSIB use only	
Claim Number	

A. Worker Identification - Please complete in full

Last Name	First Name	Worker Reference Number	Miner's Certificate Number
Address		Social Insurance Number	Years Experience in Occupation
City /Town		Occupation at Time of Injury/Awareness of Disease	
Province	Postal Code	Date of Birth dd mmm yyyy	Sex
		Date of Hire dd mmm yyyy	Date of Hire dd mmm yyyy
Worker's Preferred Language of Service			
<input type="checkbox"/> English <input type="checkbox"/> French			
Other language if worker speaks neither English/French			
Area Code		Telephone Number	
() ()			
Is the injured person a (sub) contractor, independent operator, owner, executive of the business or spouse or relative of the employer? <input type="checkbox"/> yes <input type="checkbox"/> no			

B. Employer Identification

Employer Name			Firm Number	Rate Number
Address			City /Town	Province
Postal Code				
Area Code	Telephone Number	Area Code	FAX Number	Description of Business Activity
() () ()				
Worksite Location, Branch, Plant, Department Where Worker Employed				Classification Unit Code See Instructions
Do you have an early return to work, Co-operative Return to Work program or an accommodation program in your workplace? <input type="checkbox"/> yes <input type="checkbox"/> no			Is the injured worker represented by a trade union? <input type="checkbox"/> yes <input type="checkbox"/> no	

C. Temporary Disability

Following the day that the injury/awareness of disease occurred, will the injured worker be absent from work because of the injury/disease? unknown yes no

If you answered "no" to the above, will the injured worker as a result of the injury/disease:

- assume other work duties because the injury/disease prevents them from performing their regular duties? yes no
- earn less than their regular wages because of the injury/disease? yes no

Note: If your answer is "no" to all of these questions do not complete Section F, "Earnings Information".

D. Details of Injury/Disease

Date and Hour of Injury/Awareness of Disease dd mmm yyyy a.m. p.m.	Date and Hour Reported to Employer dd mmm yyyy a.m. p.m.	Date and Hour Last Worked dd mmm yyyy a.m. p.m.	Normal Working Hours on Last Day Worked from to
Date and Hour Returned to Work dd mmm yyyy a.m. p.m.	Actual Earnings for Last Day Worked	Normal Earnings for Last Day Worked	Do you have any information that the worker could have returned to work earlier? If so, provide details.

1. What happened to cause the injury/disease? If known, describe injury, part of body involved and specify left or right side.
2. Who was the injury/disease reported to? If injury/disease was not reported immediately, provide reason for delay.
3. Describe the worker's activities at the time of the injury/disease. Include details of equipment or materials used and the size and weights of objects being handled.
4. Where was the worker when the injury/awareness of disease occurred? If the injury/disease occurred outside of Ontario, specify province, state or country.
5. Is there anyone else who may have witnessed or who may know about the injury/onset of disease? If so, provide details below.
Name(s) Address(es) and phone number(s) if available

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**Employer's Report of Injury/Disease
Form 7 (Page 2)**

Worker's Name	Social Insurance Number	WSIB use only
		Claim Number

E. Health Care

Did the worker receive health care? Initial or emergency health care: if known, provide the name and address of practitioner/facility.

yes no don't know

Current or continuing health care: if known, provide the name, address and telephone number of practitioner/facility, if different than above.

F. Earnings Information - Do not complete this section if you answered "No" to all questions in Section C on page 1.

Rate of Pay (before tax) <input type="checkbox"/> hourly <input type="checkbox"/> daily	Total Weekly Pay Hours	If weekly pay hours are irregular, please state average weekly hours.	Does the worker's work schedule change from week to week? <input type="checkbox"/> yes <input type="checkbox"/> no
From Revenue Canada TD1 provide:	Net Claim for Exemption	Net Claim Code	Enter Worker's Usual Work Days (F = full day, H = half day)
			S M T W T F S
Are Benefit Plan (Health Care, Life Insurance, Pension) contributions continuing? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not applicable			If "no", is the benefit plan a multi-employer benefit plan? <input type="checkbox"/> yes <input type="checkbox"/> no

The worker also receives the following earnings in addition to the Rate of Pay as reported above. (Check all that apply.)

- Vacation Pay
- Production Bonuses
- Profit Sharing
- Room and board and/or benefit from the worker's personal use of an employer's vehicle.
- Cost of living allowance, shift differential, lead hand premium
- Tips and Gratuities
- Unemployment insurance benefits paid in a job creation or work-sharing program

Will this benefit continue while the worker is absent from work due to this injury/disease?

- yes no
- yes no
- yes no
- yes no
- yes no
- yes no
- yes no

If "no", please state value if known

\$		<input type="checkbox"/> daily	<input type="checkbox"/> weekly
\$		<input type="checkbox"/> daily	<input type="checkbox"/> weekly
\$		<input type="checkbox"/> daily	<input type="checkbox"/> weekly
\$		<input type="checkbox"/> daily	<input type="checkbox"/> weekly
\$		<input type="checkbox"/> daily	<input type="checkbox"/> weekly
\$		<input type="checkbox"/> daily	<input type="checkbox"/> weekly
\$		<input type="checkbox"/> daily	<input type="checkbox"/> weekly

Identify Type of Employment (Check all that apply)

- Full Time Part Time Casual Seasonal Apprentice Student Learner Other

If the worker worked after the first absence, please enter dates.

From	dd	mmm	yyyy	a.m.	p.m.	To	dd	mmm	yyyy	a.m.	p.m.
------	----	-----	------	------	------	----	----	-----	------	------	------

G. Advances

If you have advanced or will be advancing anything to cover period of disability, give particulars including dates covered. If advances are to be mailed to another address, please provide.

H. Claim Information

To your knowledge has the worker had a previous similar injury/disease? yes no

If yes, provide details. If the previous similar injury/disease was work-related, include prior WCB claim number if known.

Was any individual who does not work for you totally or partially responsible for the injury/disease? yes no If yes, please explain.

If machinery, equipment or a motor vehicle was totally or partially responsible for the injury/disease, refer to the instructions on the reverse of the Employer's Copy and provide particulars.

Do you have any reason to doubt that the injury/disease is work-related? yes no If yes, please explain.

Letter of explanation attached? yes no

Who is responsible for arranging the worker's return to work? (Name and telephone number)

I. It is an offence to deliberately make false statements to the WSIB. I declare that all of the information provided on pages 1 and 2 of this report is true.

Name of Person Completing this Report	Official Title
Signature	Date
Area Code	Telephone Number

J. WORKER'S 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 Board's "Functional Abilities for Timely Return to Work" form.	
Signature	Date

0007A (02/00) **The Workplace Safety and Insurance Act requires you to give a copy of this form to your worker.**

**GUIDELINES FOR
STUDENTS ON UNPAID WORK PLACEMENTS**



Mail to: 200 Front Street West
Toronto ON M5V 3J1

FAX: (416) 344-4684
1-888-313-7373

**Employer's Report of Injury/Disease
Form 7**

(Page 3)

WSIB use only	
Claim Number	

Additional Information

Last Name	First Name	Social Insurance No.

GUIDELINES FOR STUDENTS ON UNPAID WORK PLACEMENTS

THE EMPLOYER'S REPORT OF INJURY/DISEASE INSTRUCTIONS AND REPORTING OBLIGATIONS

When should I complete this report?

This report, or a WSIB pre-approved version, must be filled out every time that you learn that a work-related injury or occupational disease has caused a worker to:

- obtain health care and/or
- be absent from their regular work
- require modified duties at less than regular pay
- require modified duties at regular pay for more than seven calendar days after the date of accident
- earn less than regular pay at regular work.

How quickly should this report be sent to the WSIB?

The law requires you to complete this form within 3 days after you learn of your reporting obligation. The WSIB requires that a completed Form 7 be received within 7 business days after you learn of your reporting obligation. You should not delay completing this report and sending it to the WSIB in Toronto.

What is meant by "health care"?

Health care includes services provided at hospitals and health facilities and services that require the professional skills of a health care practitioner, i.e. doctor, nurse, chiropractor, physiotherapist, optometrist or dentist.

You should complete this report if eye glasses, dentures and/or artificial appliances were damaged while being worn in a work-related accident.

Do I have to report injuries that require first aid only?

It is not necessary to complete this report for first-aid-only injuries handled by a health care professional or trained lay person. However, the law requires that you must keep a record of all first aid details.

First aid includes but is not limited to: cleaning minor cuts, scrapes or scratches, applying bandages and/or dressings, applying a splint.

FAILURE TO MEET REPORTING OBLIGATIONS

The WSIB will levy a penalty of \$250 for:

- late submission of this report
 - incomplete information
 - not reporting on a pre-approved version of this form, and
 - failing to provide a copy of the completed Form 7 to the worker.
- Individuals may be liable, on conviction, to a fine of up to \$25,000 or up to 6 months in jail. Corporate entities may be liable, on conviction, to fines of up to \$100,000.

After filling out this form, please print it, then sign it and:

- send a copy to the Workplace Safety & Insurance Board
- provide a copy to the injured worker, and
- keep a copy for your records.

Some employers provide a photocopy of this form to their health and safety committees in order to meet information requirements under the Occupational Health & Safety Act and regulations under that Act. Before providing a copy of this form to a health and safety committee, it is suggested that any personal information be removed.

For example:

- the worker's social insurance number
- the worker's telephone number and numbers of any witnesses
- earnings information, and
- pre-existing medical conditions, etc.

In all cases of work-related injury/onset of disease, you are required to:

- provide immediate transportation to a hospital, a doctor's office, or the worker's home, if necessary, and
- pay full wages and benefits for the day or shift on which the injury occurred.

GUIDE TO COMPLETING THE EMPLOYER'S REPORT OF INJURY/DISEASE

A. WORKER IDENTIFICATION

Social Insurance Number

The worker's social insurance number is required for T5007 reporting purposes under the Income Tax Act.

Preferred Language of Service

WSIB services to clients are available in English and French. Unless you indicate that the worker prefers French services, all services provided to the worker will be in English. If the worker speaks neither English nor French, please specify the worker's spoken language.

Worker Reference Number/Miner's Certificate Number

You may wish to record your own identification number for this claim (e.g., the worker's payroll number) in the space provided. Mining companies, including contractors doing mining work, must also enter the worker's miner's certificate number.

Date of Hire

Provide the date the worker first became an employee of your firm.

Owners, executives of the business and (sub)contractors

Employers, owners, partners, independent operators, and executive officers of a business must have personal coverage to be considered a worker for the purposes of compensation.

"Executive officer" includes anyone holding the position of Chair(man), Vice-Chair(man) of the Board of Directors, President, Vice-President, Secretary, Treasurer, or Director in a limited liability company, or General Manager or Manager designated an officer by by-law or resolution of the Directors.

B. EMPLOYER IDENTIFICATION

Please ensure that you provide address or worksite location, branch, plant or department where the worker is regularly employed.

Classification Unit

In addition to your WSIB rate number, you must also record the classification unit (CU) code representing your business activity.

If you have been assigned more than one CU code, please record the CU code which represents the business activity the worker was engaged in when injured.

If the worker was engaged in an ancillary (supportive) activity - for example, general administration - and you cannot assign the work performed to a specific CU, please assign the CU code representing the highest proportion of your annual assessable payroll.

C. TEMPORARY DISABILITY

If the answer to any of the questions in Section C is not known, please provide details.

D. DETAILS OF INJURY/DISEASE

Date and hour reported to Employer

Please fill in the date and time that the injury was first reported to an employer representative, such as first aid, immediate supervisor, time office, dispatcher, or other employer official.

Provide details of any accident which caused the injury/disease.

Examples:

The worker slipped, fell, or tripped . . . The worker was struck by . . . or bumped into . . . The worker twisted her ankle or knee . . .

If you are not aware of an accident occurring resulting in the injury/disease, describe what the worker was doing and the effort involved when an onset of pain was first noticed or when the disease was first noticed.

Examples:

The worker was in an awkward position . . . The worker was doing strenuous work . . . The work was repetitive . . . the worker was not accustomed to . . .

In cases of occupational disease, the WSIB may request more specific information.

GUIDELINES FOR STUDENTS ON UNPAID WORK PLACEMENTS

E. HEALTH CARE

Do not delay sending this report if this information is not immediately available. The worker has the right to make the initial choice of doctor or other qualified practitioner.

F. EARNINGS INFORMATION

General Information

You must fill out this section in full *unless* the worker will require first aid only and will return to work duties with full, regular wages immediately following the day of injury/onset of disease.

"Earnings" includes any payment made by an employer to a worker that can be estimated in terms of money. "Earnings" includes, but is not limited to, the worker's total regular earnings including all taxable and non-taxable benefits from employment.

If the worker's rate of pay at the time of the injury/disease is not truly indicative of the worker's regular earnings, the WSIB recalculates the average earnings by using a longer period of earnings information prior to the date of injury. The recalculation does not take effect until the worker has received 12 weeks of WSIB benefits.

Net Claim for Exemption and Net Claim Code

The WSIB requires the "net claim for exemptions" and the "net claim code" in order to calculate the worker's benefit rate. Provide this information from the Revenue Canada TD1 taxation form in effect when the injury/disease occurred. If you do not provide an exemption status, a single status will be used.

Benefit Plan contributions

The employer must continue contributions for employment benefits (including health care, life insurance, and pension benefits) for one year following the injury when the worker is absent from work because of the injury/disease. These conditions apply when;

- 1) the employer was contributing to the worker's employment benefits when the injury/disease occurred, and
- 2) the worker was contributing to employment benefits before the injury, and the worker will continue to make the same contributions while absent from work because of the injury/disease.

Multi-employer benefit plans

If a worker is a member of a multi-employer benefit plan, the plan must continue employment benefits to workers who are absent from work due to the injury/disease for one year following the injury/onset of disease and neither the employer nor the worker is obliged to continue contributions during this period. Please inform the benefit plan administrator of this obligation and dates of absence.

G. ADVANCES

You must indicate if you are continuing to pay the worker full or partial wages while the worker is absent from work. This is sometimes referred to as "salary advances" or "partial advances." The WSIB will reimburse Schedule 1 employers the amount of compensation that would normally be paid to the worker.

Additionally, the WSIB may reimburse you if you continue to pay full wages to the worker while the worker is assuming other duties that normally pay less salary.

Provide details of the alternative work arrangement resulting from the worker's injury, including the usual rate of pay at the alternative work duties. Please attach a letter if additional space is needed to provide details.

-Schedule 2 employers - please indicate if paying full advances. You will receive a "Covered by Advances" notice from the WSIB.

H. CLAIM INFORMATION

Previous similar injury/disease

Provide any information you have concerning prior similar disability, work-related or non-work-related, and details of any ongoing problems the worker has had related to prior injury/disease. Include prior workers' compensation claim numbers, if available.

Do not delay submission of this report if details are not immediately available. You may supply the additional information at a later date, by letter or by telephone.

Other individuals, machinery, equipment or motor vehicle responsible

In Schedule 1 claims, the WSIB may transfer claim costs, or may pursue court action to recover damages, in certain circumstances, such as products liability causing the injury or onset of disease. The WSIB requires that you provide the following information in these cases:

- the name and address of the manufacturer or supplier of the object, material, or equipment, if it caused or contributed to the injury/disease
- the name and address of the individual who caused or contributed to the injury/disease including the name of their employer, and
- the name and address of any employer who supplied a motor vehicle, machinery or equipment on a purchase or rental basis *without supplying workers to operate the motor vehicle, machinery, or equipment, if it caused or contributed to the injury or disease.*

Doubts that the injury/disease is work-related

Explain what the worker was doing if the worker, at the time of the injury/disease, was doing work other than for the purpose of the employer's business.

Serious and wilful misconduct

Serious and wilful misconduct is the deliberate disobedience of an expressed order, or the breach of a law or rule which is enforced and is well known to, and designed for the safety, of workers. A thoughtless act does not constitute serious and wilful misconduct. You must provide full details of the misconduct, if you feel that serious and wilful misconduct caused the injury/disease.

Once the worker is ready to return to work

Please contact the WSIB - by phone if possible - of the return to work date. This will minimize the possibility of over payment and assist in the administration of the worker's claim.

I. AUTHORIZED SIGNATURE

An employer or an authorized representative of the employer (for example, an accountant, bookkeeper, safety representative) must sign every report of injury/disease. A partner or an executive officer of the company (except a sole owner or independent operator) may *not* sign the report of their own injury/disease.

J. WORKER'S SIGNATURE

A worker may meet his or her reporting obligations by signing the Form 7. The worker's signature on the Form 7 does not necessarily mean the worker agrees with what the employer has reported on the form. The worker may always provide further information to the WSIB about the claim. If the worker meets their reporting obligation by signing the Worker's Claim/Consent Form (1492C) please write in "Worker's signature on file" in the worker's signature space on the front of the Form 7.

Please deliver this completed report, by hand, courier, mail, or FAX, to the WSIB office in Toronto. DO NOT mail original. The mailing address and fax numbers are listed on the front of this form.

GUIDELINES FOR STUDENTS ON UNPAID WORK PLACEMENTS

WSIB Workplace Safety & Insurance Board 230 Front Street West Toronto ON M5V 3J1
CSPAAT Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail 200, rue Front Ouest Toronto ON M5V 3J1

Employer's Subsequent Statement

Claim Number

Return to the Workplace Safety and Insurance Board when the injured worker returns or is able to return to work and at any other time requested. Call first to prevent overpayments.

Worker's Surname (Please print)	Given or Christian Name(s)	Date of Injury dd mmm yy
Address		Social Insurance No.
City/Town	Postal Code	Province
		Date of Birth dd mmm yyyy

1	Has the worker returned to work since the injury? If so, give date commenced.	Date Commenced	dd	mmm	yyyy	Time (hh:mm)	<input type="checkbox"/>	a.m.			
							<input type="checkbox"/>	p.m.			
2	If the worker worked after the first layoff, please enter dates.	from	dd	mmm	yyyy	Time	<input type="checkbox"/>	a.m.			
		to	dd	mmm	yyyy	Time	<input type="checkbox"/>	p.m.			
3	For Rotating Shift Workers Only, please complete the following:	Total number of shifts lost: <input style="width: 100px;" type="text"/> Number of pay hours per shift: <input style="width: 100px;" type="text"/>									
4	Did worker return as soon as able? (Give your opinion) If not, give date and time you consider worker was able. On what do you base your opinion?										
5	If unable to do former work, what kind of work is worker doing or able to do? If only able to do other than former work what do you consider services worth? When, if ever, will worker in your opinion be able to do former work?							Please express in terms of percentage	%		
6	Provide the worker's average gross weekly earnings since returning to work.	Average weekly gross earnings \$									
	Are these earnings reduced in any way?	<input type="checkbox"/> no <input type="checkbox"/> yes									
7	If the worker received any benefits or payments from your company or any other insurance plan for the period of disablement please provide the following.	Gross total payment \$	Dates from		dd	mmm	yyyy	to	dd	mmm	yyyy
		Covered: Name of insurance company, if applicable									
8	Any further information or remarks.										

Employer's name		
Authorized Signature	Official Title	Date dd-mmm-yyyy

0009C (11/98)

**GUIDELINES FOR
STUDENTS ON UNPAID WORK PLACEMENTS**

Appendix C

**GUIDELINES FOR
STUDENTS ON UNPAID WORK PLACEMENTS**



Ministry of
Training, Colleges and
Universities

Ministère de la Formation
et des Collèges
et Universités

Mowat Block
900 Bay St.
Toronto ON M7A 1L2

édifice Mowat
900, rue Bay
Toronto ON M7A 1L2

Letter of Authorization to Represent Employer

This section to be completed by Training Agency

Please be advised that the following Training Agency will serve as the Employer's representative in matters pertaining to WSIB in this work related injury.

Training Agency _____

Address _____

City, Province _____

Postal Code _____ Firm # _____

Contact Person _____ Telephone # _____

This section to be completed by Placement Employer

_____, unpaid training participant is claiming that he/she
(Training Participant's Name)
suffered a work related injury on _____ while on work placement with our
(Date)
company.

Company Name _____

Address _____

City, Province _____

Postal Code _____ Firm # _____

Contact Person _____ Telephone Number _____

Placement Employer's Authorization Signature

Date

To be attached to Form 7 and sent to WSIB.

**GUIDELINES FOR
STUDENTS ON UNPAID WORK PLACEMENTS**

Appendix D

MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES

ACE INA INSURANCE STATISTICS

Training Agency Name _____

Contact Person _____

Telephone Number _____

PERIOD May 1, to August 31, 2001

UNPAID WORK PLACEMENT WITH EMPLOYERS OUTSIDE THE *WORKPLACE SAFETY AND INSURANCE ACT* ELIGIBLE FOR INSURANCE COVERAGE THROUGH ACE INA

PROGRAM	TOTAL HOURS OF WORK PLACEMENT	NUMBER OF STUDENTS		APPLICATION INDUSTRY
		GRANT-ELIGIBLE	VISA	
A. Postsecondary				
B. Tuition Short (Fee-paying)				

**GUIDELINES FOR
STUDENTS ON UNPAID WORK PLACEMENTS**

Appendix E

**GUIDELINES FOR
STUDENTS ON UNPAID WORK PLACEMENTS**



ACE INA Insurance
ACE INA Life Insurance
 The Exchange Tower
 130 King Street West, 12th Floor
 Toronto, Ontario M5X 1A6
 Telephone: 416-368-2911 1-877-772-7797

**ACCIDENTAL MEDICAL
CLAIM FORM**

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Policy No. _____

Name		
Date of Birth	Phone # ()	
Address		
City	Province	Postal Code
Name of Employer		Employer Phone # ()
Have you previously submitted a claim to ACE INA? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of accident
How did the accident occur?		
What injuries resulted from the accident?		
Date physician first consulted?		
Name and address of physician?		

The above statements are true and correct to the best of my knowledge and belief. I authorize, for a period of not less than twelve (12) and twenty-four (24) months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, insurance company, workers compensation board or similar plan or organization, the plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with ACE INA Insurance or ACE INA Life Insurance, or its representatives, all medical or benefit payment information or any other information or records in its possession that the Insurer may request while administering my claim. I agree that a photocopy of this authorization shall be as valid as the original.

Claimant's Signature _____ Date _____

**ARE YOU COVERED BY ANOTHER INSURANCE COMPANY FOR ACCIDENT?
(IF SO, PLEASE ADVISE NAME OF COMPANY AND PROVIDE YOUR POLICY AND CERTIFICATE NUMBERS)**

Date Service Rendered	Nature of Illness	Name of Service Drugs & RX No	Name of Pharmacist	Amount Charged	Name of Doctor Prescribing Service

**IMPORTANT: ALL BILLS AND ORIGINAL PRESCRIPTION DRUG RECEIPTS,
MUST BE ATTACHED TO THIS CLAIM FORM**

06A/04/2003

**GUIDELINES FOR
STUDENTS ON UNPAID WORK PLACEMENTS**

Statement of Authority

Name of Insured
Policy No.
We certify that the above claimant is insured for the term commencing _____ and ending _____
Date

Signature of Person Authorized by Policyholder _____

Insured's Statement

I hereby certify that the above information is true and correct and that all expenses listed were incurred only by the patient indicated. I understand that ACE INA Insurance or ACE INA Life Insurance may contact my doctor, pharmacist, or any other person and I hereby authorize the release of whatever additional information may be required and that a photocopy of this release shall be deemed as valid as the original.

Date _____

Insured's Signature _____

THIS FORM AND ALL ATTACHMENTS WHICH YOU ARE REQUIRED TO PAY MUST BE FORWARDED WITHOUT DELAY.

**GUIDELINES FOR
STUDENTS ON UNPAID WORK PLACEMENTS**



ACE INA Insurance
ACE INA Life Insurance
 The Exchange Tower
 130 King Street West, 12th Floor
 Toronto, Ontario M5X 1A6
 Telephone: 416-368-2911 1-877-772-7797

**PROOF OF LOSS/DISMEMBERMENT/FRACTURE CLAIM
 ATTENDING PHYSICIAN'S STATEMENT**

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

Full Name of Insured
Date of Birth

History

a) When did symptoms first appear or accident happen?	
b) Date patient ceased work because of disability	
c) Has patient ever had same or similar condition? <input type="checkbox"/> Yes (state when & describe) <input type="checkbox"/> No <input type="checkbox"/> Unknown	
d) Is condition due to injury or sickness arising out of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
e) Names of any other treating Physicians	Address
Names of any other treating Physicians	Address

Diagnosis, Nature of Loss

a) Primary (If fracture, state bone fractured; if dislocation, state whether complete or incomplete. Please attach x-rays/operative report for all fractures.)
b) Secondary (if applicable)
c) Did any disease or previous injury contribute to the loss? Please provide details.
d) Is loss permanent and irrecoverable? Please provide details.

Treatment

a) Date of first visit
b) Date of latest visit
c) Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify)
d) Date of Hospitalization: Confined From: _____ To: _____
Hospital Name
e) Nature of Treatment (including medication, therapy and surgery, if any)

Physical Impairment

Degree of limitation of Functional Capacity
<input type="checkbox"/> Class 1 - No limitation: Capable of heavy work. No Limitations. (0-10%)
<input type="checkbox"/> Class 2 - Slight limitation: Capable of light manual activity. (15%-30%)
<input type="checkbox"/> Class 3 - Moderate limitation: Capable of Clerical/Administrative (sedentary) activity. (35-55%)
<input type="checkbox"/> Class 4 - Marked limitation. (60-70%)
<input type="checkbox"/> Class 5 - Severe limitation: Incapable of minimal (sedentary) activity. (75-100%)
Remarks

80A/10/2004

**GUIDELINES FOR
STUDENTS ON UNPAID WORK PLACEMENTS**

PROOF OF LOSS/DISEMBLEMENT/FRACTURE CLAIM ATTENDING PHYSICIAN'S STATEMENT Page 2

Visual *if applicable*)

(For loss of vision due to accident only)			
What was vision at latest observation?	With glasses:	O.D.	O.S.
	Without glasses:	O.D.	O.S.
Vision can be restored in whole or part by: O.D. <input type="checkbox"/> Lenses <input type="checkbox"/> Treatment <input type="checkbox"/> Operation <input type="checkbox"/> Not Restorable			
O.S. <input type="checkbox"/> Lenses <input type="checkbox"/> Treatment <input type="checkbox"/> Operation <input type="checkbox"/> Not Restorable			

Remarks

Name of attending Physician	Degree
Phone # ())	Fax # ())
Address	

Signature _____

Date _____

PLEASE NOTE THAT ALL CHARGES FOR THE COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF THE CLAIMANT