Workplace Safety & Insurance Board
200 Front Street West
Toronto ON M5V 3J1
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.

Last Name	First Name		Date of Injury (dd / mmm / yy yy)
Address			Social Insurance No.
City/Town	Province	Postal Code	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 ☐ a.m. ☐ p.m.
2	If the worker worked after the first layoff, please enter dates.	**from**	dd / mmm / yyyy	Time ☐ a.m. ☐ p.m.
		to	dd / mmm / yyyy	Time ☐ a.m. ☐ p.m.
3	For Rotating Shift Workers Only, please complete the following:	**Total number of shifts lost:**		
		Number of pay hours per shift:		
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?	☐ no ☐ yes		
7	If the worker received any benefits or payments from your company or any other insurance plan for the period of disable-ment please provide the following.	Gross total payment $	**Dates Covered:** from dd mmm yyyy to dd mmm yyyy	
		Name of insurance company, if applicable		
8	Any further information or remarks.			

Employer's name (Please print)

Authorized Signature	Official Title	Date

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