WSIB Workplace Safety & Insurance Board
ONTARIO CSPAAT Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

Worker's Exposure Incident Form

WSIB Use Only

Firm No.	Rate No.	Classification Unit Code	Claim No.

The following information will assist the Workplace Safety and Insurance Board (WSIB) in recording a workplace exposure incident. Please provide as much detail as possible to ensure that the incident is accurately recorded.

Your Information

Last Name	Given Name	Maiden Name (if applicable)

Address (street address/city/town/province)

	Postal Code

Telephone Number ( )	Sex ☐ male ☐ female	Date of Birth (dd/mm/yyyy)	Social Insurance No.

Your Employer's Information

Employer's Name (at time of incident)	Date of Hire (dd/mm/yyyy)

Describe the Nature of your Employer's Business	Your Occupation/Job Title

Employer's Address (street address/city/town/province)

	Postal Code

Location of the Incident

Details of Incident

Complete Section A for an exposure to an infectious substance, or
Section B for an exposure to chemical or other workplace substances.

Section A - (Infectious Substance)

	Date (dd-mm-yyyy)	**Time**

Please describe how you came into contact with the infectious substance (please check):

☐ cut or scrape ☐ body fluid splash ☐ cough, sneeze ☐ other (specify)

Source of exposure	Area of Body Affected

What infectious substance is suspected? (please check):

☐ tuberculosis ☐ meningitis ☐ rabies ☐ hepatitis ☐ anthrax ☐ campylobacter

☐ salmonella ☐ scabies ☐ shingles ☐ don't know ☐ other (specify):

If you experienced any illness related to this incident, please complete a Worker's Report of Injury/Disease (Form 6). For further information, please contact 1-800-465-9646.

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Section B - (Chemical or Other Workplace Substances)

Date (dd-mm-yyyy)	Time

Please describe, in detail, what occurred: (please check):

☐ leak ☐ spill ☐ explosion ☐ other (specify)

Please describe where you were at the time and how long you were in the affected area.
(If it would be helpful, attach a diagram to describe the event or another sheet for added information).

What personal protective equipment were you wearing at the time?

In the event that this exposure results in an illness that entitles you to benefits under the Workplace Safety and Insurance Act (the Act), by signing this form , you consent to the release of functional abilities information as required in section 22(5) of the Act, in the event there is a right to benefits.

Signature	Date

When completed, please mail to:

Program for Exposure Incident Reporting (PEIR)
Workplace Safety and Insurance Board
200 Front Street West
Toronto ON M5V 3J1

Completing this form is voluntary. Your personal information is collected under the authority of the Workplace Safety and Insurance Act, 1997, S.O. 1997, c. 16, Schedule A, and will be used to record your unplanned exposure incident. This information may be disclosed for workplace health and safety and accident prevention purposes, as permitted by the Freedom of Information and Protection of Privacy Act. Questions about the collection should be directed to the Workplace Safety & Insurance Board, PEIR Team Manager, 200 Front Street West, Toronto, Ontario, M5V 3J1.
Please call: (416) 344-1010 or toll free 1-800-465-9646.