

**WSIB Use Only**

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

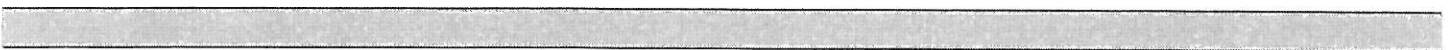
Last Name	Given Name	Maiden Name (if applicable)
Address (street address/city/town/province)		
		Postal Code
Telephone Number ( )	Sex <input type="checkbox"/> male <input type="checkbox"/> female	Date of Birth (dd/mm/yyyy)
		Social Insurance No.

**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
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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
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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.

