WSIB ONTARIO CSPAAT

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

OR FaxTo:
416-344-4684
OR 1-888-313-7373

print reset

WREO7

Employer's Continuity Report (Form WREO7)

start

Claim Number	Desk No.	Alloc. No.

Please PRINT in black ink

Worker's Name	Worker's Reference Number	Original Date of Accident/Injury
Accident Employer Name	**Injury**	**Date of Recurrence/Re-injury**

1. a) Describe what the worker reports as the cause of this recurrence.

b) Date of reporting dd mm yy

2. a) Did the worker receive health care for this present recurrence? ☐ yes ☐ no If yes, when? dd mm yy

b) When did the employer learn that the worker received health care? dd mm yy

c) Where was worker treated for this present recurrence?

☐ On-site medical ☐ Emergency department ☐ Health professional office ☐ Clinic ☐ Other .....

Name/location of health professional/facility

3. Are you aware of any factors or other problems, aside from the original work injury, which may have contributed to this worker's present recurrence? ☐ yes ☐ no If **yes**, provide details here **or** ☐ Submission attached

4. From to , has this worker been performing his/her regular work duties? ☐ yes ☐ no

If **no**, describe the work duties performed

5. From to , has this worker reported or discussed any ongoing problems with anyone at work about this condition?

☐ yes ☐ no If **yes**, names and positions

6. From to , has this worker sought any medical treatment for this condition? ☐ yes ☐ no ☐ unknown

If **yes**, from who? ☐ Chiropractor ☐ Physiotherapist ☐ Hospital ☐ Physician ☐ Registered Nurse (extended class) ☐ Other (specify) .....

7. Between to , did this worker miss any time from work due to this condition? ☐ yes ☐ no

If **yes**, provide dates.

8. Choose **one** of the following indicators. **As a result of this recurrence/re-injury, this worker:**

☐ Returned to his/her **regular work** and **has not** lost any time and/or earnings. (Complete **only** page **1**)

☐ Returned to **modified work** and **has not** lost any time and/or earnings. (Complete **only** page **1**)

☐ **Has** lost time and/or earnings. (Complete pages **1 and 2**)

Date worker first lost time and/or earnings dd mm yy → Date worker returned to work (if known) dd mm yy ☐ regular work ☐ modified work

9. This Lost Time - No Lost Time - Modified Work information was confirmed by: Phone Ext.

☐ Myself ☐ Other (Name)

It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I declare that all of the information provided on pages 1 and 2 is true.

Name of person completing this report (please print)	Official title		
Signature	**Phone**	**Ext.**	**Date (dd/mm/yy)**

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WREO7E

Post -1998 - Re-open Claim Earnings (Form WREO7E)

Report the worker's earnings at the time of the recurrence.

Worker Name	Original Date of Accident/Injury **(DOA)**	Claim Number / Date of Recurrence/Re-injury
		Claim Number:
		Date of Recurrence/Re-injury:

start

1. Regular rate of pay $ _____ per ☐ hour ☐ day ☐ week ☐ other _____

2. Net Claim Code or Amount
Federal _____ Provincial _____

3. Vacation pay on each cheque? ☐ yes ☐ no Provide percentage _____ %

4. Actual working hours on last day worked
From ☐ AM ☐ PM To ☐ AM ☐ PM

5. Normal working hours for last day worked
From ☐ AM ☐ PM To ☐ AM ☐ PM

6. Actual earnings on last day worked $ _____

7. Normal earnings for last day worked $ _____

8. Advances on Wages
Is the worker being paid while he/she recovers? ☐ yes ☐ no
If yes, indicate: ☐ Full/Regular ☐ Other ▶ Paid by ☐ Employer ☐ Third Party/ Insurance Plan
If by a third party/insurance plan, provide Name _____ Phone _____

9. **Other Earnings (Not Regular Wages):** Provide the **total of additional earnings** for each week for the 4 weeks before the recurrence/re-injury.

* For Rotational Shift workers - If the shift cycle exceeds 4 weeks, please attach the earnings information for the last complete shift cycle prior to the date of recurrence/re-injury

▼ Use these spaces for any other earnings (indicate Differentials, Premiums, Tips, etc.).

Period	From Date (dd/mm/yy)	To Date (dd/mm/yy)	Mandatory Overtime Pay	Voluntary Overtime Pay				
Week 1			$	$	$	$	$	$
Week 2			$	$	$	$	$	$
Week 3			$	$	$	$	$	$
Week 4			$	$	$	$	$	$

Regular Production Bonuses/Commission

If paid weekly Did this worker receive payment in each of the 4 weeks before the layoff? ☐ yes ☐ no If yes, what is the average gross weekly amount? $ _____

If paid monthly Did this worker receive payment in each of the 3 months before the layoff? ☐ yes ☐ no If yes, what is the average gross monthly amount? $ _____

Is worker receiving any payments in lieu of benefits? ☐ yes ☐ no If yes, what is the % _____

10. **Work schedule** (complete either A or B or C, **do not** include overtime shifts.)

(A) **Regular Schedule -** Indicate normal work days and hours.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Example

S	M	T	W	T	F	S
	8	8	8	8	8	

(B) **Repeating Rotational Shift Worker -** Provide:

NUMBER OF DAYS ON	NUMBER OF DAYS OFF	HOURS PER SHIFT(s)	NUMBER OF WEEKS IN CYCLE

Example: 4 days on, 4 days off, 12 hours per shift, 8 weeks in cycle

(C) **Varied or Irregular Work Schedule -** Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the recurrence/re-injury. (Do not include overtime hours or shifts here).

	Week 1	Week 2	Week 3	Week 4
From/To Dates (dd/mm/yy)				
Total Hours Worked				
Total Shifts Worked				

Signature _____ Date (dd/mm/yy) _____

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