WSIB CLIENT INFORMATION

PATIENT INFORMATION:

NAME: ____

DATE OF BIRTH: ______________________________________

SOCIAL INSURANCE NUMBER: ___________________________

WSIB CLAIM NUMBER (If known): _______________________

DATE OF ACCIDENT: ___________________________________

EMPLOYER INFORMATION:

NAME OF EMPLOYER: __________________________________

ADDRESS: _____________________ CITY: _________________

PROVINCE: ________________ POSTAL CODE: _____________

TELEPHONE NO:_________________ FAX NO: _______________