

# Health Professional's Report (Form 8)

For

Chiropractors

Physicians

Physiotherapists

Registered Nurses (Extended Class)

## Health Professionals, please use this form when:

- Your patient states that an injury/illness is related to his or her work.
- You believe that the cause of your patient's injury/illness is due to workplace factors.
- Your patient states that his or her current condition is a recurrence or re-injury of a previous work-related injury/illness. (Provide the patient's claim number from the previous injury/illness – if available).

Section 37 of the *Workplace Safety and Insurance Act, 1997* provides the legal authority for health professionals, hospitals and health facilities to submit, without consent, information relating to a worker claiming benefits to the Workplace Safety and Insurance Board (WSIB).

Your promptness in completing this form is key to our ability to process and adjudicate your patient's claim. Your patient, their employer and the WSIB depend on you.

When completing this report, please **print** using **black pen**.

Your patient should complete Section A of this report. If your patient needs assistance, please help. Please submit this report even if Section A is not fully completed.

Information for completing this report can be found on **Page 4**. For more details, refer to "Guidelines for Health Professionals – Completing WSIB Forms".

Please separate and send **Pages 2 and 3** to the Workplace Safety and Insurance Board:

### By Fax to:

416 344 4684 or 1 888 313 7373

### Or by Mail to:

Workplace Safety and Insurance Board  
200 Front Street West  
Toronto, ON M5V 3J1



Workplace Safety &  
Insurance Board

Commission de la sécurité  
professionnelle et de l'assurance  
contre les accidents du travail

Safety starts with you

[www.wsib.on.ca](http://www.wsib.on.ca)

**A. Patient and Employer Information (Patient to Complete this Section)**

Last Name		First Name		Init.
Address (no. street, apt.)				
City/Town		Prov.	Postal Code	Telephone No. ( )
Social Insurance No.		Job Title/Occupation		Health Card No. Code
Date of Birth	dd mm yy	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Language <input type="checkbox"/> Eng. <input type="checkbox"/> Fr.	
Does your employer have work duties that you can do while recovering?			<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Business or Company Name			Supervisor/Contact Name	
Address (no. street, apt.)				
City/Town		Prov.	Postal Code	Telephone No. ( )
Did you tell your employer about this injury/illness?		Help us serve you better by telling us the size of your company:		
<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> Small (1-19 workers), <input type="checkbox"/> or Large (20 +)		
The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the <i>Workplace Safety and Insurance Act</i> . The Social Insurance Number is used to register claims, identify workers and to issue income tax information statements as authorized by the <i>Income Tax Act</i> . The Health Card Number is collected under the authority of the <i>Health Card and Numbers Control Act</i> and is used for health administration and planning, research and studies. Questions? Contact the WSIB Privacy Officer at 1-800-387-5540 ext. 5323 or direct at 416 344-5323.				

**B. Health Professional Billing Information**

<input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Registered Nurse (Extended Class)				Service Code
Health Professional Name (please print)				<b>FORM8</b>
Address (no. street, apt.)				WSIB Provider ID.
City/Town				Your Invoice No.
Prov.		Postal Code	FAX No. ( )	

**C. Incident Dates and Details Section**

1. What is your understanding as to how this injury/illness or re-injury occurred?			Date of Accident/ Recurrence (dd/mm/yy)
2. Have you previously treated this patient for this injury? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please list dates of treatment since your last report:			
3. Are you this patient's primary Health Professional? <input type="checkbox"/> yes <input type="checkbox"/> no	Location of this assessment <input type="checkbox"/> Office <input type="checkbox"/> Walk-in Clinic <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Other	<input type="checkbox"/> Workplace	Date of this assessment (dd/mm/yy)
4. Did another Health Professional assess this patient before you? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, where and when did this take place?		Date (dd/mm/yy)

**D. Clinical Information Section**

**1. Area of Injury (Body Part) - (Please check all that apply)**

<input type="checkbox"/> Brain	<input type="checkbox"/> Ears	<input type="checkbox"/> Upper back	Left	Right	Left	Right	Left	Right	Left	Right
<input type="checkbox"/> Head	<input type="checkbox"/> Teeth	<input type="checkbox"/> Lower back	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eyes	<input type="checkbox"/> Chest	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other:			<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2. Type/Nature of Injury - (Please check all that apply)**

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Disc Herniation	<input type="checkbox"/> Puncture	<input type="checkbox"/> Asthma
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Repetitive Strain Injury	<input type="checkbox"/> Dermatitis
<input type="checkbox"/> Avulsion	<input type="checkbox"/> Epicondylitis	<input type="checkbox"/> Spinal Cord Injury	<input type="checkbox"/> Fumes - Inhalation
<input type="checkbox"/> Bite	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Burn	<input type="checkbox"/> Ganglion	<input type="checkbox"/> Tendonitis/Tenosynovitis	<input type="checkbox"/> Infectious Disease
<input type="checkbox"/> Contusion/Hematoma	<input type="checkbox"/> Hernia		<input type="checkbox"/> Needle Stick
<input type="checkbox"/> Crush Injury	<input type="checkbox"/> Laceration		<input type="checkbox"/> Poisoning/Toxic Effects
<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/> Pain - Indeterminate Origin	<input type="checkbox"/> Other	<input type="checkbox"/> Psychological



## Health Professional's Report (Form 8)

### Guidelines for Completion

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The following information provides some assistance in completing the Form 8. For additional details please see "Guidelines for Health Professionals – Completing WSIB Forms".

#### Section A - Patient and Employer Information (Patient to complete this section)

- The information in this section helps to register and administer the patient's claim. It also ensures that the Health Professional's report is sent to the correct claim file. If a patient is unable to complete this section, the Health Professional can assist.
- The patient's personal information is collected under the authority of *The Workplace Safety and Insurance Act* and is used to administer the claim. For more information contact the WSIB Privacy Office toll-free at 1-800-387-5540 ext. 5323 or (416) 344-5323.
- If the patient is unable to supply the SIN and OHIP numbers, or other information, the form should still be completed and submitted to the WSIB.

#### Sections B, C, D and E (to be completed by the Health Professional)

##### Section C – Incident Dates and Details Section

- "Did another Health Professional assess this patient before you?" Check (✓) Yes or No. "If yes, where and when did it take place?" Please provide this information, if you can. It will enable the WSIB to request a report from the other Health Professional.

##### Section D – Clinical Information Section

Please check (✓) all that apply. Include all relevant clinical and/or objective findings or symptoms. Space has been provided for any additional findings/symptoms not listed, or for any other details.

##### Section E – Treatment Plan & Return to Work Information

- "Please indicate the patient's status and task limitations in relation to the diagnosis." Always complete this question and check (✓) all that apply:
  - A. "No limitations": Patient is able to return to work now; no task limitations needed.
  - B. "Specified Limitations (Please Specify)": Please check all limitations that apply (e.g. standing, sitting, lifting). If you wish to provide further details, please use the space provided.
  - C. "No Return to Work (*Rationale Required*)": If the patient is unable to return to work in any capacity, the WSIB needs to know why in order to make a determination on entitlement to benefits. Use the space provided to give us this information.
- Please note: You can check more than one status or time period if needed and give an explanation in the space provided e.g., - No return to work for 1 - 2 days, then a return to work with a lifting limitation for 3 - 7 days.
- "From the date of this assessment, the above status(es) will apply for approximately." Check (✓) the time period. Please note that for anything beyond 14 days, the WSIB will request a Progress Report.

This Health Professionals Report (Form 8) is not intended to replace the  
Functional Abilities Form for Timely Return To Work (FAF).

If your patient or the employer requests a FAF, please complete as usual.