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

Worker's Exposure Incident Form

The attached **Worker's Exposure Incident Form** (form 3958A) is intended for voluntary use when an unplanned workplace incident exposure has resulted from a leak, spill, explosion, release, or an unexpected contact with a chemical or other substance. The event may have exposed workers to an infectious, chemical or other substance. The purpose of this form is to obtain information about the exposure incident experienced by the worker should an illness or disease occur in the future.

The **Worker's Exposure Incident Form** should be completed if you have experienced an unplanned workplace exposure where there has been:

- no lost time
- no illness

If you are experiencing any illness needing medical treatment, (*such as diagnostic tests, prescribed medication or ongoing treatment*) please complete a Worker's Report of Injury/Disease (Form 6).

Forms should be completed and forwarded to:

By Mail
Workplace Safety and Insurance Board
Occupational Disease and Survivor Benefits Program
200 Front Street West, 4th Floor
Toronto, Ontario M5V 3J1

By Fax
416-344-4684
1-888-313-7373

To report an exposure incident by telephone or for questions concerning the Worker's Exposure Incident Reporting Form, please contact us at:

Toll Free:	1-800-387-0750
Local Dialing:	416-344-1000
Website:	www.wsib.on.ca
TTY:	1-800-387-0050

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Worker's Exposure Incident Form

WSIB Use Only

Firm No.	Rate No.	Classification Unit Code	Reference 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	Sex ☐ male ☐ female	Date of Birth (dd/mm/yyyy)

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 of Exposure** (dd/mm/yyyy) | **Time of Exposure**

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 1-800-387-0750.

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Reference No.

Details of Incident ...(Continued)

Section B - (Chemical or Other Workplace Substances)	**Date of Exposure** - (dd/mm/yyyy)	**Time of Exposure**

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	Type your name and upload, or print and sign before returning to WSIB.	Date

SUBMITTING THE EXPOSURE INCIDENT FORM TO THE WORKPLACE SAFETY AND INSURANCE BOARD

If your employer is reporting the exposure you may provide this form to them to include with their submission. You may also choose to forward the form directly to the WSIB.

By Mail
Workplace Safety and Insurance Board
Occupational Disease and Survivor Benefits Program
200 Front Street West, 4th Floor
Toronto, Ontario M5V 3J1

By Fax
416-344-4684
1-888-313-7373

Personal information about you will be collected throughout your claim under the authority of the *Workplace Safety and Insurance Act, 1997*. Your personal information will be used to administer your claim(s) and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, Canada Revenue Agency (CRA), and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax statements and is collected under the authority of the *Income Tax Act*.

Information may only be disclosed to the employer, external medical consultants, external service providers, researchers, third parties for cost recovery purposes and others as authorized by the *Workplace Safety and Insurance Act* and the *Freedom of Information and Protection of Privacy Act*. Your name and telephone number may be disclosed to third parties conducting satisfaction surveys and focus groups. Incoming and outgoing calls may be recorded for quality assurance purposes. Questions about this collection should be directed to the decision maker responsible for your file or by calling **1-800-387-0750**.