Martin
CHIROPRACTIC

**292 King Street West, Oshawa Ontario, L1J 2J9, 725-4020**

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## WORKPLACE SAFETY & INSURANCE BOARD

The information requested is used in determining your entitlement to compensation, therefore, please complete fully.

Name (in full) :_____
Address :_____
City :_____Postal Code :_____
Age :_____Sex :_____E-Mail address:_____
Social Insurance Number :_____
Occupation :_____
Employer's Name :_____
Employer's Address :_____
Claim Number :_____Date of Accident :_____
Date of first visit to this office :_____
Has this accident been reported to your employer?_____
Have you had a previous similar disability?_____If so, when? _____
Are you off work?_____Date you last worked :_____
Who rendered first treatment?_____
Have you seen another doctor for this injury?_____If so, whom?_____
Please explain what you were doing at the time you were injured (lifting, walking, carrying, climbing, standing, stooping, etc.):_____

_____

_____

Where did you feel the pain?_____

_____

When did you first notice the pain?_____

I understand that if my WSIB claim is rejected I am personally liable and agree to pay for any outstanding account balance regarding adjustments received at Martin Chiropractic.

Signature:_____