

Mail To:
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Toronto ON M5V 3J1

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

REO6

Worker's Continuity Report (Form REO6)

Claim Number	Desk No.	Alloc. No.
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Please PRINT in black ink

Worker's Name	Are you still with the same employer as when you were originally injured? <input type="checkbox"/> yes <input type="checkbox"/> no	
Original Date of Accident/Injury	Date of Recurrence/Re-Injury	If no , provide your new employer name and address
Injury	May we contact your new employer? <input type="checkbox"/> yes <input type="checkbox"/> no	

1. a) Do you feel your present problems are the result of your original work injury? yes no
b) From _____ to _____, describe why it is worse along with any details or changes to your condition.

2. From _____ to _____, have you had any medical treatment for your work injury? yes no
If **yes**, who did you see and how often?

3. From _____ to _____, list the names of any drugs/medications or assistive devices/braces you have been using for ongoing problems related to your work injury.

4. From _____ to _____, have there been any changes to the **work** that you have been doing? yes no
If **yes**, describe the changes.

5. From _____ to _____, have you reported or discussed any ongoing problems with anyone at work? yes no
If **yes**, names and positions.

6. From _____ to _____, did you miss any time from work due to your work injury? yes no
If **yes**, what are those dates?

7. Choose **one** of the following: **Due to this present recurrence:**

I have returned to **regular work** and **have not** lost time and/or pay. (complete **only** question **8**)

I have returned to **modified work** and **have not** lost time and/or pay. (complete **only** questions **8 and 9**)

I **have** lost time and/or pay → Date you first lost time and/or pay dd mm yy (complete **only** questions **10 to 12**)
for this present recurrence

8. Was your return to work to a) <input type="checkbox"/> regular work OR <input type="checkbox"/> modified work b) <input type="checkbox"/> regular pay OR <input type="checkbox"/> lower pay c) <input type="checkbox"/> regular hours OR <input type="checkbox"/> less hours	9. Date of your return to work dd mm yy
10. Have you talked to your health professional about return to work? <input type="checkbox"/> yes <input type="checkbox"/> no If yes , date of last discussion dd mm yy and have they determined your work limitations or functional abilities? <input type="checkbox"/> yes <input type="checkbox"/> no	11. Have you talked to your employer about return to work? <input type="checkbox"/> yes <input type="checkbox"/> no If yes , date of last discussion dd mm yy name of person you talked to _____
12. Is there an anticipated return to work date? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes , what is the return to work date dd mm yy

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 this page is true.

By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the WSIB's "Functional Abilities Form for Planning Early and Safe Return to Work."

Signature	Date (dd/mm/yy)
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