

Construction Exposure Incident Reporting (CEIR) Form

The attached **Worker's Exposure Incident Reporting Form** (form 3885A) is intended for voluntary use when an unexpected workplace incident exposure has resulted from a leak, spill, rupture, unanticipated emission, explosion or a release of a dangerous chemical or physical substance or contact with an infectious substance or biological agent.

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.

This form should be completed by the worker who has experienced an unexpected exposure.

Employers complete an Employer's Exposure Incident Reporting Form (CEIR) (Form 3886A).

The **Worker's Exposure Incident Reporting Form** should only be completed if there has been an unexpected workplace exposure event where there has been:

- no lost time
- no illness

If you have experienced any illness needing medical treatment (such as diagnostic tests, prescribed medication or ongoing treatment) as a result of the incident, the employer should file an occupational disease claim using a Form 7. The worker should file an occupational disease claim using a Form 6.

Forms should be completed and given to your supervisor/Health and Safety Representative to forward to the WSIB. Completed forms can also be forwarded 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

To report an exposure incident by telephone or for questions concerning the Worker's Exposure Incident Reporting Form – CEIR, 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

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 your 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 <input type="checkbox"/> male <input type="checkbox"/> female	Date of Birth (dd/mm/yyyy)	Social Insurance No.

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
Firm No.	Rate No.
Classification Unit Code	
Employer's Address for Correspondence (street address/city/town/province)	
Postal Code	
Location of Exposure Incident	
Does the project or workplace have a functioning Joint Health and Safety Committee (JHSC)? <input type="checkbox"/> yes <input type="checkbox"/> no	Does the project or workplace have a Joint Health and Safety Representative? <input type="checkbox"/> yes <input type="checkbox"/> no
If the answer is yes to either or both of the above questions, please attach the report of the Joint Health and Safety Committee or the Joint Health and Safety Representative.	
If the answer is no to the above questions, please attach the report of the exposed worker(s) if available.	
Are you a member of a union? <input type="checkbox"/> yes <input type="checkbox"/> no	If yes, please provide your union name and local.

Details of Incident		
If you experienced any illness related to this incident, please do not complete this form. Please complete a Worker's Report of Injury/Disease (Form 6). For further information, please contact 1-800-387-0750 .		
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 Substances	Date of Exposure (dd/mm/yyyy)	Time of Exposure
What type of exposure was involved? (please check):		
<input type="checkbox"/> cut or scrape <input type="checkbox"/> body fluid splash <input type="checkbox"/> cough, sneeze <input type="checkbox"/> other (please specify) _____		
Source of exposure	Area of Body Affected	
What infectious substance is suspected? (please check):		
<input type="checkbox"/> tuberculosis <input type="checkbox"/> meningitis <input type="checkbox"/> rabies <input type="checkbox"/> hepatitis <input type="checkbox"/> anthrax <input type="checkbox"/> campylobacter		
<input type="checkbox"/> salmonella <input type="checkbox"/> scabies <input type="checkbox"/> shingles <input type="checkbox"/> don't know <input type="checkbox"/> other (please specify) _____		

Reference No.

Details of Incident ...(Continued)

Section B - (Chemical or Other Workplace Substances)	Date of Exposure (dd/mm/yyyy)	Time of Exposure
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Please describe, in detail, what occurred: (please check):

leak rupture explosion
 spill unanticipated emission other (please specify) _____

What chemicals or workplace substances were you exposed to?

Please describe where you were at the time of the exposure 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	Date
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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

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Completing this form is voluntary. Your personal information is collected under the authority of the Workplace Safety and Insurance Act, 1997, S.O. 1997, c. 16, Schedule A, and will be used to record your unplanned exposure incident. This information may be disclosed for workplace health and safety and accident prevention purposes, as permitted by the Freedom of Information and Protection of Privacy Act. Questions about the collection of information should be directed to the Workplace Safety & Insurance Board, 200 Front Street West, Toronto, Ontario, M5V 3J1. Please call: (416) 344-1000 or toll free 1-800-387-0750 .