WSIB ONTARIO Workplace Safety & Insurance Board

CSPAAT 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 ongoing 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).

Please mail the completed form to:

**Program for Exposure Incident Reporting (PEIR)**
**Workplace Safety and Insurance Board**
**200 Front Street West, 4th Floor**
**Toronto ON M5V 3J1**

For more information, please contact us at (416) 344-1010 or toll free 1-800-465-9646.

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

Reset | Reset Page 1 | Print

# Worker's Exposure Incident Form

**WSIB Use Only**

| Firm No. | Rate No. | Classification Unit Code | Claim No. |
|---|---|---|---|
| START HERE > | | | |

**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 Number ( ) | Sex ☐ male ☐ 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 |
|---|---|
| | |

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** (dd-mm-yyyy) | **Time** |
|---|---|---|
| | | |

**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 1-800-465-9646.**

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

Reset Page 2

# Worker's Exposure Incident Form

Claim Number

**Section B - (Chemical or Other Workplace Substances)**

START HERE >

| **Date** (dd-mm-yyyy) | **Time** |
|---|---|
| | |

**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

**Please print form, sign & date before returning to the WSIB**

When completed, please mail to:

**Program for Exposure Incident Reporting (PEIR)**
**Workplace Safety and Insurance Board**
**200 Front Street West**
**Toronto ON M5V 3J1**

**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 should be directed to the Workplace Safety & Insurance Board, PEIR Team Manager, 200 Front Street West, Toronto, Ontario, M5V 3J1.**
**Please call: (416) 344-1010 or toll free 1-800-465-9646.**

Print