wsib ONTARIO

Employer's subsequent statement

Submit this form and supporting documents at wsib.ca/submit

9 **Claim number**

Submit this form at wsib.ca/submit once claimant returns to work. Call first to prevent overpayments.

Last name	First name		Date of injury (dd/mmm/yy)
Address			
City/town	Province	Postal code	Date of birth (dd/mmm/yy)

1	Has the claimant returned to work since the injury? If so, give date commenced.	Date commenced (dd/mmm/yy)	Time	☐AM ☐PM
2	If the claimant worked after the first layoff, please enter dates.	From (dd/mmm/yy)	Time	☐AM ☐PM
		To (dd/mmm/yy)	Time	☐AM ☐PM
3	Please only complete the following if the claimant works rotating shifts:	Total number of shifts lost: Number of pay hours per shift:		
4	Did the claimant return as soon as able? If not, what date and time was the claimant able? Provide details.			
5	If unable to do former work, what kind of work is claimant able to do? What do you consider the worth of these services? When, if ever, will the claimant be able to do former work?	Please express in terms of percentage		%
6	Provide the claimant's average gross weekly earnings since returning to work. Are these earnings reduced in any way?	Average weekly gross earnings $ ☐Yes ☐No		

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

Ce document est disponible en français sous le titre : *Déclaration complémentaire de l'employeur,* 0009B (05/23)

Claim number

7	If the claimant received any benefits or payments from your company or any other insurance plan for the period of disablement please provide the following:	Gross total payment $ Name of insurance company, if applicable	Dates covered (dd/mmm/yy) From To
8	Additional comments.		

Employer's name		
Signature	Official title	Date (dd/mmm/yy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.