# 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 |

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

# Worker's Exposure Incident Reporting Form - CEIR

## WSIB Use Only

| Firm No. | Rate No. | Classification Unit Code | Reference No. |
|---|---|---|---|
| | | | |

Start >

**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 ☐ male ☐ female | Date of Birth (dd/mm/yyyy) |
|---|---|---|
| | | |

## 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)? ☐ yes ☐ no | Does the project or workplace have a Joint Health and Safety Representative? ☐ yes ☐ 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? ☐ yes ☐ 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):

☐ cut or scrape ☐ body fluid splash ☐ cough, sneeze ☐ other (please 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 (please specify) _____

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Reference No.

## Details of Incident ...(Continued)

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

**Date of Exposure** (dd/mm/yyyy)

**Time of Exposure**

**Please describe, in detail, what occurred:** (please check):

- ☐ leak
- ☐ spill
- ☐ rupture
- ☐ unanticipated emission
- ☐ explosion
- ☐ 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 **Type your name and upload, or print and sign before returning to WSIB**

Date

### 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**
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Occupational Disease and Survivor Benefits Program
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Personal information about you will be collected throughout your claim under the authority of the *Workplace Safety and Insurance Act, 1997*. Your personal information will be used to administer your claim(s) and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, Canada Revenue Agency (CRA), and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax statements and is collected under the authority of the *Income Tax Act*.

Information may only be disclosed to the employer, external medical consultants, external service providers, researchers, third parties for cost recovery purposes and others as authorized by the *Workplace Safety and Insurance Act* and the *Freedom of Information and Protection of Privacy Act*. Your name and telephone number may be disclosed to third parties conducting satisfaction surveys and focus groups. Incoming and outgoing calls may be recorded for quality assurance purposes. Questions about this collection should be directed to the decision maker responsible for your file or by calling **1-800-387-0750**.