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

# Employer's Exposure Incident Reporting Form - CEIR

The attached **Employer's Exposure Incident Reporting Form** (form 3886A) 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 supervisor and/or the Joint Health and Safety Committee Representative. Workers wishing to participate in the CEIR Program should complete a Worker's Exposure Incident Reporting Form (CEIR) (Form 3885A).

The **Employer'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 workers are experiencing 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.**

Forms should be completed and forwarded to:

**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 |



next page

print reset save

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

# Employer's Exposure Incident Reporting Form - CEIR

**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.**

## Section 1. Employer's Information

Start >

Employer's Name (at time of incident)

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

Employer's Address for Correspondence (street address/city/town/province)

| | Postal Code |
|---|---|
| | |

Address for Location of Incident (street address/city/town/province)

| | Postal Code |
|---|---|
| | |

What is the nature of your business?

## Section 2. Additional Employer's Information

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.

Is the worker covered by a Union/Collective Agreement? ☐ yes ☐ no

If yes, please provide your union name and local.

## Please list all workers involved in the exposure incident (Use additional sheet if necessary).

| **1. Last Name** | Given Name | Date of Birth (dd/mm/yyyy) | Date of Hire |
|---|---|---|---|
| Address (street number & address/city/province) | | | |
| Postal Code | Telephone | Sex ☐ male ☐ female | Social Insurance No. |

| **2. Last Name** | Given Name | Date of Birth (dd/mm/yyyy) | Date of Hire |
|---|---|---|---|
| Address (street number & address/city/province) | | | |
| Postal Code | Telephone | Sex ☐ male ☐ female | Social Insurance No. |

| **3. Last Name** | Given Name | Date of Birth (dd/mm/yyyy) | Date of Hire |
|---|---|---|---|
| Address (street number & address/city/province) | | | |
| Postal Code | Telephone | Sex ☐ male ☐ female | Social Insurance No. |

| **4. Last Name** | Given Name | Date of Birth (dd/mm/yyyy) | Date of Hire |
|---|---|---|---|
| Address (street number & address/city/province) | | | |
| Postal Code | Telephone | Sex ☐ male ☐ female | Social Insurance No. |

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

# Employer's Exposure Incident Reporting Form - CEIR

**If you have your own incident reporting form, completion of this portion of the form is not required. Please attach your reporting form. You may, however, be contacted for further information.**

## 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 Substances)

| **Date of Exposure** (dd/mm/yyyy) *Start >* | **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) _____

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

| **Date of Exposure** (dd/mm/yyyy) | **Time of Exposure** |
|---|---|

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

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

What chemical or other workplace substance was the worker exposed to?

**Please describe where the worker(s) were at the time and how long they were in the affected area.**
(What personal protective equipment was being worn by worker(s)? What emergency measures were taken after the incident? What was done to control the situation? If it would be helpful, attach a diagram to describe the event or another sheet for added information.)

Were any WSIB claims for an illness, condition or disease related to this incident? ☐ yes ☐ no

**Other Reporting of This Incident**

| | | | |
|---|---|---|---|
| Was a formal report of the incident made to the Ministry of Labour? | ☐ yes ☐ no | If **yes**, did Ministry of Labour officials come to the premises because of the incident? | ☐ yes ☐ no |
| Was a formal report of the incident made to the Ministry of the Environment? | ☐ yes ☐ no | If **yes**, did Ministry of the Environment officials come to the premises because of the incident? | ☐ yes ☐ no |
| Is any information available about the substance(s) involved in the incident such as MSDSs? | ☐ yes ☐ no | Was environmental sampling done following the incident? | ☐ yes ☐ no |

| Name of Person Completing Report | Official Title | |
|---|---|---|
| Signature *Type your name and upload, or print and sign before returning to WSIB.* | Telephone | Date (dd/mm/yyyy) |

## SUBMITTING THE EXPOSURE INCIDENT FORM TO THE WORKPLACE SAFETY AND INSURANCE BOARD

If the worker(s) experiencing the unexpected workplace incident are reporting their exposure, please attach all copies of the Worker's Exposure Incident Forms and forward to:

**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