wsib ONTARIO

COVID-19 initial contact screening questionnaire

Claim number

Name	Date of birth (dd/mmm/yyyy)

1. Your employer has submitted a claim for you indicating you may have contracted COVID-19 at work. Are you claiming WSIB benefits because you believe you may have contracted COVID-19 at work or due to your job?

☐ Yes ☐ No (We will withdraw your claim. Do not complete the remaining questions.)

2. Please provide details about how and when you believe you contracted COVID-19. For example, were you in contact with a person at work who had a confirmed or probable diagnosis of COVID-19? How did you contract COVID-19 at work?

3. Have you experienced any symptoms of COVID-19? If so, when did you first start experiencing them?

☐ Yes Date that symptoms began:

Describe your symptoms:

☐ No

4. Have you been tested for COVID-19?

☐ Yes. Type of test: ☐ Molecular test (PCR or rapid molecular testing) ☐ Rapid antigen test (work or home-based)

Date of initial test: Location of initial test:

Initial test result: ☐ Positive ☐ Negative

Date of repeat/confirmatory test: Location of repeat test /confirmatory test:

Repeat test result: ☐ Positive ☐ Negative

Please submit a copy of your test results with your claim number at wsib.ca/submit.

☐ No. Reason for not being tested:

5. Have you seen a doctor or health care professional, received treatment, or been hospitalized for COVID-19? ☐ Yes ☐ No

If yes, indicate whether virtual or in person:

For each health care provider or hospitalization, please complete the fields below:

A. Date of medical visit(s) and/or hospitalization:

B. Name of provider, address, phone and fax information:

C. Description of tests, treatment and/or referrals related to COVID-19 diagnosis:

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

200 Front Street West, Toronto, Ontario, M5V 3J1
wsib.ca/submit | **Toll free:** 1-800-387-0750 | **TTY:** 1-800-387-0050 | **Fax:** 1-888-313-7373

6. A. What is your job title?

B. Please describe your job duties and work environment (indoors or outdoors, work from home, factory, warehouse, office, etc,)

7. Have any of your household members or close friends who you see often been diagnosed with COVID-19?

☐ Yes ☐ No

If yes, did they develop symptoms or were they diagnosed in the two weeks before you developed COVID-19? Please provide details without including names:

8. Please describe any activities you participate in outside of work, such as sports, going to the gym, social activities or attending places where you interact with other people:

In any of your activities that you participate in outside of work, were you exposed to a person or people with confirmed or probable COVID-19 in the two weeks before you were diagnosed with COVID-19?

☐ Yes ☐ No

9. Have you lost time or wages from work because of COVID-19?

☐ Yes

Dates of lost time:

Reason for lost time (select all that apply):

☐ Positive COVID-19 test

☐ Self-isolation/quarantine as a precaution

☐ COVID-19 symptoms

☐ Other (Please specify):

☐ No

10. Have you returned to work?

☐ Yes. Please provide your return-to-work date:

☐ No. A. What is your expected return-to-work date?

B. Do you have medical authorization to be off work beyond 10 days from the onset of your symptoms?

☐ Yes ☐ No

Submit forms and documents related to your claim at wsib.ca/submit

11. Please provide any additional information that you think may be relevant to your COVID-19 claim:

Acknowledgement:

☐ By checking this box, I, , acknowledge and agree that:

- The information I have provided is truthful.
- I understand that it is an offence to deliberately make false statements to the Workplace Safety and Insurance Board.

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