WSIB PATIENT INFORMATION SHEET

NAME: ____ WSIB CLAIM #:_______________

ADDRESS: ____ CITY: ____________________

POSTAL CODE: ______________ HOME #:__________________ CELL #: __________________

WORK #: ________________ EMAIL ADDRESS: ______________________________________

BIRTHDAY (Y/M/D/): __________ ______________ HEALTH CARD #: ____________________

DOCTOR'S NAME: ____________________________DOCTOR'S PHONE #: _________________

DATE OF ACCIDENT: __________________EMPLOYER NAME:____________________________

EMPLOYER ADDRESS: ____

EMPLOYER PHONE #: ____