



# MSI-1

## WORKERS INJURY REPORT

Do not write here

### A. WORKER INFORMATION

Last Name	First Name	Social Insurance Number
Address		Telephone
City/Town	Province	Postal Code
Date of birth	Male or Female	Cell Phone
What is your occupation?		Medicare number
Do you have more than 1 job?		
If you have more than 1 job will this injury prevent you from working at your other job?		
Weekly wages at the time of the accident		

### B. EMPLOYER INFORMATION

Company Name		
Address		
City/Town	Province	Postal Code
Supervisors Name		Company Telephone

### C. ACCIDENT/ILLNESS DATES AND DETAILS

<b>Date and Hour of accident</b>			Last day that you worked?	
Day	Month	Year	Exactly who did you report this accident too?	
AM	PM	Time		
Where exactly on job-site did the injury occur?				

**What part of your body did you injure?**

### D. Describe in detail exactly what happened

**Were there any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, please give us their names & positions.**

**ADDITIONAL INFORMATION**

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**E. DECLARATIONS AND SIGNATURE**

By signing below, I am declaring that all the information provided here is true and correct. I am also authorizing any and all health professional who treats me to provide me, my employer and MSI with any and all information that is required, including all past medical files.

**IT IS AN OFFENCE TO DELIBERATELY MAKE FALSE STATEMENTS TO MSI**

Signature	day	month	year

If you are under 16 yrs of age, your parent or guardian, must authorize the release of your information

Signature	Relationship	day	month	year

- I hereby Authorize any hospital, Physician, or other person who has attended me or the claimant to furnish to MSI or its representatives any and all information with respect to any illness or injury, medical history, consultations, prescriptions or treatment, and all copies of all hospital or medical records, a photo copy of this Authorization shall be considered as effective and valid as the original. \_\_\_\_\_
- I hereby authorize the release to MSI any information requested in respect of this claim. \_\_\_\_\_
- MSI reserves the right to investigate if a claim was made to another insurer or government agency for the same incident. \_\_\_\_\_
- The furnishing of this form or its acceptance is not an admission of liability by MSI or a waiver of any conditions of the coverage. M.S.I. reserves the right to bring action to recover any benefit paid to an insured employee resulting from an accident caused by a third-party. The beneficiary accepts to transfer all his rights to recover and authorize M.S.I. to enforce such rights in his/her name. \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_