MOHAWK SELF INSURANCE

MSI-1

WORKERS INJURY REPORT

Do not write here

A. WORKER INFORMATION

Last Name: Doe	First Name: John	Social Insurance Number: 123-456-789
Address: P.O. Box 1		Telephone: 450-635-5555
City/Town: Kahnawake	Province: Quebec	Postal Code: J0L 1B0
Date of birth: January 1, 1995	Male or Female: M	Cell Phone: 514-123-4567
What is your occupation? Truck Driver		Medicare number
Do you have more than 1 job? no		
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: $800 a week		

B. EMPLOYER INFORMATION

Company Name: ABC Trucking		
Address: 123 maple street		
City/Town: Kahnawake	Province: QC	Postal Code: J0L-1B0
Supervisors Name: Dave Smith		Company Telephone: 450-555-1234

C. ACCIDENT/ILLNESS DATES AND DETAILS

Date and Hour of accident

Day	Month	Year
01	01	2015

AM	PM	Time
X		8:15

Last day that you worked? January 1, 2015

Exactly who did you report this accident too? my boss Dave Smith

Where exactly on job-site did the injury occur? in the truck yard

What part of your body did you injure? → Ankle (R)

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.

I was walking to my company truck when I stepped up to foot peg on truck I slipped on ice and sprained my ankle. I went to nearest CLSC.

No witnesses

ADDITIONAL INFORMATION

Doctors note attached

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
John Doe	01	01	2015

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: John Doe Date: January 1, 2015