Confidential-Use for Workplace Insurance Purposes Only and Shred.

Workers' Compensation Board | Commission des accidents du travail | 2 Bloor Street East Toronto, Ontario M4W 3C3

Physician's First Report

For W.C.B. > Use Only

Message to Doctor:

- **Please complete in full and mail within 48 hours if the patient's injury/disease is believed to be work related.**
- Section 53 of the Workers' Compensation Act authorizes you to release this information to the WCB.
- To ensure prompt processing of the claim please remind the patient to report the accident to the employer.
- Supplies of Physician's First Report, Form 8, are available on request from Agency Registration Clerks at Head Office.

ID & Reg - RP
☐ E.H

Please complete in black ink or type and submit the original.

MAR 0 1 1997

Firm No.	Rate No.	Cl[redacted]

Patient's Last Name: Taylor — First: Paul

Full [redacted]

City [redacted]

Are [redacted]

Employer's Name: Action Force / Canadian Tire

Full Address: 89 Dundas St. E.

City/Town: Mississauga — Province: ON — Postal Code:

Area Code: 905 — Phone No.: 897 8933 — Date of Accident: day 6 month 2 year 97

For W.C.B. > Use Only: Status | Injury | Injury | Claims Adjudicator

1. **Date of your first treatment** 10/2/97
2. **Who rendered first treatment?** myself — Date 10/2/97
3. **Patient's history of injury** A stack of storage bins fell on his back
4. **Prior history of similar medical condition.** none
5. **Symptoms and specify physical findings.** Pain with flexion and rotation to right @ L5 spine. Pain at Thoracic spine
6. **Diagnosis** Strain / Contusion of back
7. **Investigations ordered/Results** none
8. **Describe Current Treatment Program or Proposed Treatment including physiotherapy/chiropractic/medications, etc.:** Rest + Range of motion exercises

Referral to a Community Clinic Yes / No

9. **Referral to Specialist:** Name of Specialist(s) (please print): none — Date(s) of Appointment:
10. **Complete recovery expected?** Yes / No — If yes, approximate time? 2-3 wks
11. **List any medical restrictions** that should be observed when the patient returns to work activities now. Should not return until reassessed 13/2/97
12. **Are there medical restrictions which prevent this patient from operating a motor vehicle?** Yes / No — If yes, describe
13. **Can patient use public transport?** Yes / No

Health Insurance No. [redacted]

Physician's Name - please print: R Sculs

Address: 205-2300 Eglinton Ave W — City/Town: Mississauga

Province: ON — Postal Code: L5M 2K8 — Area Code: 905 — Phone No: 820-8144

Agency (WCB Registration No.): 324082-S MAR 03 PAID

Physician's Signature: R Sculs — Date: 10/2/97

Your Own Account No.:

Service Date (d d m m y y): 10 02 97 — Fee Code: M640

0008C (07/90)

Form 8 (Français au verso)

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