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Workers' Compensation Board / **Commission des accidents du travail**
200 Front Street West
Toronto ON
M5V 3J1

Worker's Report of Injury/Disease Form 6

Claim No.	Desk No.	Alloc. No.
[redacted]	1263	B25

Injury	
NECK	BACK OF HEAD

Date	Date of Injury
16MAR97	06FEB97

Employer's Name and Address
723739 ONTARIO INC
5805 WHITTLE ROAD
UNIT#101
MISSISSAUGA ON CAN
L4Z 2J1

To Enquire, Contact
M. BAIRD
(416) 344-2657
For toll free number, check local directory.

Ce formulaire est disponible en français sur demande.

PAUL TAYLOR
[redacted]

A. Personal Information

Social Insurance Number [redacted] | Date of Birth

Preferred Language: [X] English [ ] French [ ] Other

B. Employment Information

Job at time of injury: Driver / unloader.

Date of Hire: day | month | year

Date started on job: day | month | year

C. Accident Details

Date of injury: day 06 | month 02 | year 97

Date Reported: day 06 | month 02 | year 97

Reported to: Name: Monique Rivard

Position: Dispatch / supervisor

Lost time from work: [ ] No [Y] Yes — From: day 06 | month 02 | year 97 — To: day | month | year

Still off work: [X] Yes

Daily/Hourly Rate: 15.50

Working Days: s [ ] m [X] t [X] w [X] th [X] f [X] s [ ]

Hours per week: 60

What part/s of your body was/were injured?
back, back of neck, back of Head.

IF YOU CAN IDENTIFY A SPECIFIC INCIDENT THAT CAUSED YOUR INJURY, ANSWER THE FOLLOWING QUESTIONS. IF YOUR CONDITION CAME ON GRADUALLY OVER TIME, PLEASE ANSWER QUESTIONS ON THE BACK OF THIS FORM.

Describe what happened to cause your injury (ie. lifted box, slipped on wet floor). Please indicate the size and weight of any objects involved.
load Fell on Driver (myself) when I was uload at a canduin Tire store in Aldershot on. Aprox. 6 Grey bins 150(lbs Aprox.) and Ten cases of oil (Aprox 15olbs, Fell on My ~~lower~~ back, Neck and head.

Name any witnesses or co-workers aware of your in[redacted] - store Employee who witnessed The Incident. Monique Rivard (Action Force) Person Notified.

If you delayed in reporting your accident, explain why:

0006A (02/97)

Please read and complete the relavant parts on the back of this form

IF YOUR CONDITION CAME ON GRADUALLY OVER TIME, ANSWER THE FOLLOWING QUESTIONS.

1. Describe the work you do and what you believe caused your condition. Include the size and weight of any objects you use. How many times per hour/day do you go through the same motion? I drive Truck (Tractor-Trailer) under contract(driver service) To Canadian TireCorp. Working There I Physically unload. The load which is crammed into the Trailer and loaded by hand To The roof (Not High) which means as You are unloadding the Load becomes very unstab and boxes start To Fall on You. Amounts of weight Lifted is From 1 lb to 300-400 lbs. Amount of Time unloading a Trailer in a day is From 8 hr - 10 hr.

2. When did you first notice the pain? Were there any changes to your job at that time such as increased production rate, longer work hours or equipment/line changes? There was pain (severe) Right after The incident and has at times Increased and decreased with depending on The amount of sitting and Standing.

3. Did you mention your pain to any supervisors or co-workers? Please provide the names, positions, and approximate dates and frequency of complaints.

4. Are you left or right handed? ☐ Left ☒ Right

5. When did you first go to First Aid or a doctor? Dr. R. Sauls (Family Doctor) day 4 month 02 year 97

D. General Information

Name of Doctor: Dr. R. Sauls.

Telephone No. [redacted]

Address: 2300 Eglinton Ave. W Suite 205 Mississauga

Province: Ontario

Postal Code: L5M 2V8

Date seen: day 04 month 02 year 97

PLEASE LET YOUR DOCTOR(S) KNOW YOUR WCB CLAIM NO.

Prior similar injury/condition? ☒ No ☐ Yes

If yes, any previous claims? ☐ WCB ☐ Other (explain) _____

Are you a member of a union? ☒ No ☐ Yes

If yes, do you authorize the union to represent you in matters before the Workers' Compensation Board? ☐ No ☐ Yes

If yes, give the name and telephone number of the union representative.

It is an offence to deliberately make false statements to the WCB.

I consent to the collection of all information relating to this claim by the WCB. I declare all of the information in this report is true and I claim benefits under the Workers' Compensation Act.

Signature [signature] Date Apr 2/97 Telephone No. [redacted]

In accordance with the Freedom of Information and Protection of Privacy Act, your employer can obtain a copy of this form from the WCB.