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]	1220	828

Injury: LEFT HAND

Date	Date of Injury
26JAN96	14DEC95

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

To Enquire, Contact:
T. MCGLADE
(416) 344-2639
For toll free number, check local directory.

Ce formulaire est disponible en français sur demande.

PAUL TAYLOR
[redacted]

1996 FEB 29 AM 9:51

MESSAGE TO WORKER:

Please use dark ink. When you have filled out this report, immediately return it to the WCB. If you do not return this report to the WCB you will delay compensation payments, your right to rehabilitation services, and other benefits.

Personal information relating to you will be collected throughout your claim under the authority of the Workers' Compensation Act, and will be used to administer your claim and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, employers and witnesses. Information may be disclosed to the accident employer, external medical, rehabilitation, safety agencies and others as authorized by the Workers' Compensation Act and the Freedom of Information and Protection of Privacy Act. For information about the collection, and availability of this form to your employer, contact the decision maker responsible for your file.

Worker Information

Your Name, Home Address with Postal Code if missing or different from above.
Name:

Address:

City/Town | Province | Postal Code

Date of Birth | Social Insurance Number
[redacted]

Your Preferred Language of Service
☒ English ☐ French

Other language if you speak neither English/French

Job at time of injury/onset of disease: Driver / unloader

Date started work with employer: day | month | year

Are you:
☒ Full Time ☐ Part Time ☐ Casual ☐ Seasonal ☐ Apprentice ☐ Student ☐ Learner ☐ Other

Health Care

Where were you first treated for your injury/disease? (first aid at work, clinic, hospital, emergency, family doctor, chiropractor)
credit Valley Hospital Eglinton Ave Miss. ONT.

Date of First Treatment: day 14 | month 12 | year 95

Name and address of person treating you now.
Dr. R. Sauls Eglinton Ave Miss. on t.

Most Recent Appointment: day 20 | month 2 | year 96

If you have been referred to any health care specialist (physiotherapist, chiropractor, surgeon), give name(s).

Date of Appointment: day | month | year

Earnings Information

Your employer reported your earnings to the WCB on the Form 7. Please review the information in section F of your copy of the Employer's Report of Injury/Disease, Form 7. If you disagree with the earnings information provided by your employer, or if you wish to add more information, please provide details. Attach a letter of explanation and/or a pay stub to this form, if applicable.

Employment Benefits

(Note: Under certain conditions your employer must continue to make contributions to your employment benefits throughout 1 year following your injury)

Check off the employment benefits provided or contributed to on your behalf by your employer: ☐ Health Care ☐ Life Insurance ☐ Pension

Do you contribute to your employment benefits? ☒ yes ☐ no

0006A (11/93)

Please read and complete the back of this form

Worker's Name
Paul Taylor

[redacted]

723739 ONTARIO INC
5805 WHITTLE RD #101
MISSISSAUGA ON CAN

L4Z 2J1

Details of Injury/Disease

Date and Hour of Injury/ Awareness of Disease (day / month / year)	(am / p.m.)
14 / Dec / 95 / 7	am / p.m.
Date and Hour Reported to Employer (day / month / year)	**(am / p.m.)**
14 / Dec / 95 / 9:30	am / p.m.
Who did you report the injury/disease to?	
CTC Dispatch.	

1. What happened to cause your injury/disease? If known, describe injury, part of body involved and specify left or right side.
Metal wiper Blades/Instead of plastic winter blades summer
2. If you did not report your injury/disease immediately, why did you delay in reporting your injury/disease?
could not get down to office
3. Describe your activities at the time of the injury/disease. Include details of equipment or materials you used and the size and weights of objects you handled.
wipers froze up pulled over turn wiper off (thought I had, but turned to intermitted) went grab blade finger got caught when wiper came on.
4. Where were you when the injury/disease occurred? If your injury/disease occurred outside Ontario, specify province, state or country.
401 - Guelph ONT.
5. Did anyone else witness or know about your injury/onset of disease? If so, provide details below.
Name(s) — Work address(es) and phone number(s) if available

Have you ever had a similar injury/disease? ☒ no ☐ yes If yes, provide details in the space below. If the previous injury was work-related, include prior WCB claim number, if known. If additional space is needed, attach a letter.

Date of Injury	Type of Injury	Name & Address of your employer at the time of previous injury, if applicable	Claim Number

Have you returned to any work, with or without pay, since your injury/disease? ☐ no ☒ yes If yes, give name of employer and dates worked.
Same Company. Dec 15/95 — ON

Are you a member of a trade union? ☒ no ☐ yes

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

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

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 [redacted] Date Feb 20/96 Area Code Telephone [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.

[redacted]

Physician's First Report
Form 8

Message to Physician:

- **Please complete in full and mail to the WCB within 48 hours if the patient's injury/disease is work related.**
- Section 51 (R.S.O. 1990) 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 your local WCB office.

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

For WCB use only >

Firm No.	Rate No.	Claim No.

Patient's Last Name: Taylor — First Name: Paul

Full Address (No., Street, Apt.): [redacted]

City/Town: Mississauga — Province: Ontario — Postal Code: [redacted]

Area Code | Phone No. — Social Insurance No. — Date of Birth: [redacted]

Employer's Name: Action Force

Full Address: 89 Dundas St W.

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

Area Code | Phone No. — Date of Accident: day 14, month 12, year 95

For WCB use only > Status | Injury | Claims Adjudicator

1. Date you first treated injured worker: [redacted] 14/12/95
2. Who rendered first treatment? Credit Valley Hospital Emergency Department — Date: 14/12/96
3. Patient's history of injury/disease: Cut left 2nd finger on windshield wiper blade.
4. Prior history of similar medical condition: N/A
5. Symptoms and specify physical findings: Laceration left 2nd finger, distally
6. Diagnosis: Laceration of left 2nd finger
7. Will the worker be absent from work because of the workplace injury/disease on the day after it occurred? ☒ no ☐ yes
8. Investigations ordered/Results: none
9. Describe current or proposed treatment/program including physiotherapy/chiropractic/medications, etc.: Sutured. tetanus prophylaxis
   Referral to a community clinic ☒ no ☐ yes
10. Referral to specialist: Name of specialist(s) (please print): N/A — Date(s) of appointment: N/A
11. Complete recovery expected? ☐ no ☒ yes — If yes, approximate time?
12. List any medical restrictions that should be observed when the patient returns to work activities now: limited use of left hand for one day after injury
13. Are there medical restrictions which prevent this patient from operating a motor vehicle? ☒ no ☐ yes
14. Can the patient use public transport? ☐ no ☒ yes

Physician's name - please print: R. Sauls

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

Province: Ontario — Postal code: L5M 2A8 — Area code | Phone No.: 905 820-8144

Physician's signature: R Sauls — Date: 20/2/96

Health No.: [redacted] — Version Code:

WCB Agency Billing No.: [redacted]

Your own invoice No. — Service date (d d m m y y): 20 02 96 — Fee code: M 8 | 4 | 0

(06/94)

(Français au verso)

THE CREDIT VALLEY HOSPITAL
2200 EGLINTON AVENUE WEST
MISSISSAUGA, ONTARIO L5M 2N1
EMERGENCY TREATMENT RECORD

Field	Value
Patient ID Number	087784
Admission Date	14 12 95
Attending or Emergency Physician	Moore
Patient Surname	TAYLOR
Given Name	PAUL
Family Physician	SAULS, ROBERT
Telephone	820-8144
Street Address	[redacted]
Health Number	[redacted]
City	MISSISSAUGA
Prov.	ON
Postal Code	L5C 4C5
Telephone	[redacted]
Date of Birth	[redacted]
Age	29
Sex	M
Marital Status	S
Responsible for Payment	WCB
Accident Date	14/12/95
S.I.N.	[redacted]
Means of Arrival	CAR
Accompanied by	BRO
Name and Address of Employer	ACTION FORCE/CANADIAN TIRE, 89 DUNDAS STREET EAST, MISSISSAUGA
Person to Notify in Case of Emergency	[redacted]
Telephone	[redacted] 7
Allergies	NKA
Presenting Complaint	WCB-LACERATION LD2
Triage Priority	P 3
T / P / R	36.3 / 76 / 20
Tetanus Status	U

Times: 1409, 1434, Seen by M.D. 16:00

POOR QUALITY ORIGINAL

History & Findings

29 yr old ♂ lacerated (L) digit #2 while working - cut ex [illegible] blade. ? last tetanus - will see F.D.

PMHx ∅ ∅meds ∅allergies.

PSHx [illegible] smokes 1ppd.

OK - NAD.

(L) Digit #2 laceration neurovasc intact.

Dr. Grant Moore
211 St. Patrick St., Suite 606
Toronto, Ontario M5T 2Y9 (416) 591-2339

Physician's Signature: Moore Date: Dec 20/95

LABORATORY: CBC, Blood Sugar, Electrolytes, Urea, Creatinine, Amylase, Blood Gases, R&M, ECG, Old Charts

POOR QUALITY ORIGINAL

B.Reg.-NM E.H. JAN 23 1996

Treatment: Procedure: ring block 1% lidocaine w/o [illegible] sutured with 4-0 Dermalon

Discharge: Light duties. Tylenol for pain. See fam Doc for tetanus. Follow wound care sheet. Suture removal 7 days

Discharge Diagnosis: Laceration

WCB Agency Billing No.: 651093-50

Service Date: 14 12 95 Fee Code: M161410

Attending MD Signature: Moore.

6300 HR(12/94)

EMERGENCY TREATMENT RECORD

Action Force

20

January 31, 1996

Workers' Compensation Board
200 Front Street West
Toronto, Ontario
M5V 3J1

Attention: Client Services Divison

Dear Sir/Madam:

056/1220

Re: [redacted] Paul TAYLOR

I have received a notice from you stating that the injury was reported by someone other than our company. I have done a Social Insurance Number check and cannot find this worker as employed by us. We are a temporary service agency and these workers work at various client companies. No accident or injury was reported to Action Force in regards to the the above named worker by the injured party or by the client.

It would be of great assistance if you could provide us with the name of the client company where this supposed left hand injury took place or the branch office out of which this worker was dispatched.

At any rate we have no knowledge of the incident and without the further above requested information, we cannot pursue the matter.

Yours truly,

C. Panciw

Mrs. C. Panciw
WCB Administrator