



Workplace Safety &
Insurance Board

Commission de la sécurité
professionnelle et de l'assurance
contre les accidents du travail

Worker's Exposure Incident Form

The attached **Worker's Exposure Incident Form** (form 3958A) is intended for voluntary use when an unplanned workplace incident exposure has resulted from a leak, spill, explosion, release, or an unexpected contact with a chemical or other substance. The event may have exposed workers to an infectious, chemical or other substance. The purpose of this form is to obtain information about the exposure incident experienced by the worker should an illness or disease occur in the future.

The **Worker's Exposure Incident Form** should be completed if you have experienced an unplanned workplace exposure where there has been:

- no lost time
- no ongoing illness

If you are experiencing any illness needing medical treatment, (*such as diagnostic tests, prescribed medication or ongoing treatment*), please complete a **Worker's Report of Injury/Disease** (Form 6).

Please mail the completed form to:

**Program for Exposure Incident Reporting (PEIR)
Workplace Safety and Insurance Board
200 Front Street West, 4th Floor
Toronto ON M5V 3J1**

For more information, please contact us at (416) 344-1010 or toll free 1-800-465-9646.

WSIB Use Only

| | | | |
|----------|----------|--------------------------|-----------|
| Firm No. | Rate No. | Classification Unit Code | Claim No. |
|----------|----------|--------------------------|-----------|

The following information will assist the Workplace Safety and Insurance Board (WSIB) in recording a workplace exposure incident. Please provide as much detail as possible to ensure that the incident is accurately recorded.

Your Information

| | | |
|---|--|-----------------------------|
| Last Name | Given Name | Maiden Name (if applicable) |
| Address (street address/city/town/province) | | |
| | | Postal Code |
| Telephone Number () | Sex <input type="checkbox"/> male <input type="checkbox"/> female | Date of Birth (dd/mm/yyyy) |
| | | Social Insurance No. |

Your Employer's Information

| | |
|--|---------------------------|
| Employer's Name (at time of incident) | Date of Hire (dd/mm/yyyy) |
| Describe the Nature of your Employer's Business | Your Occupation/Job Title |
| Employer's Address (street address/city/town/province) | |
| Postal Code | |
| Location of the Incident | |

Details of Incident

Complete **Section A** for an exposure to an infectious substance, or **Section B** for an exposure to chemical or other workplace substances.

Section A - (Infectious Substance)

| | |
|-------------------|------|
| Date (dd-mm-yyyy) | Time |
|-------------------|------|

Please describe how you came into contact with the infectious substance (please check):

- cut or scrape body fluid splash cough, sneeze other (specify)

| | |
|--------------------|-----------------------|
| Source of exposure | Area of Body Affected |
|--------------------|-----------------------|

What infectious substance is suspected? (please check):

- tuberculosis meningitis rabies hepatitis anthrax campylobacter
 salmonella scabies shingles don't know other (specify):

If you experienced any illness related to this incident, please complete a Worker's Report of Injury/Disease (Form 6). For further information, please contact 1-800-465-9646.

