OSSTF WORKERS' COMPENSATION FACT REPORTING FORM

Worker's Name: _____ Claim #: _____

Accident Date: _____

Worker's Address: _____

_____

Telephone #: Home (____) _____ Work (____) _____

Name of Your Union Representative: _____

District: _____ Local #: _____

Workplace Location: _____

Social Insurance # (optional): _____

Birth Date: Day _____ Month _____ Year _____

Family Doctor: _____ Telephone #: (___) _____

Address: _____

_____

Specialist: _____ Telephone #: (___) _____

Address: _____

_____