Confidential-Use for Workplace Insurance Purposes Only and Shred.

Workers' Compensation Board / Commission des accidents du travail — Ontario

Employer's Report of Injury/Disease
Form 7 (Page 1)

Ce formulaire est disponible en français sur demande.

- **Please read the instructions on the reverse of the Employer's Copy (yellow copy).**
- **Please type or print firmly in dark ink.**
- **Do not fold page 2 under page 1 when completing the form.**

97 FEB 10 PM 2:20

WCB use only
Claim Number [redacted]

A. Worker Identification

Last Name	First Name
TAYLOR	PAUL

Address [redacted]
City /Town
Province

ID & Reg - NM
☐ E.H.
FEB 10 1997

Worker Reference Number	Miner's Certificate Number
T707	
Social Insurance Number	**Years Experience in Occupation**
[redacted]	1

Occupation at Time of Injury/Awareness of Disease: TRUCK DRIVER

Date of Birth (day month year)	Sex	Date of Hire (day month year)
[redacted]	M	16 MAR 1995

Worker's Preferred Language of Service: ☐ English ☐ French
Other language if worker speaks neither English/French

Fold

Is the injured person a (sub) contractor, independent operator, owner, executive of the business or spouse or relative of the employer? ☐ yes ☒ no

Area Code Telephone Number: (905) 949-0637

B. Employer Identification

Employer Name	Firm Number	Rate Number
ACTION FORCE	240062HM	570

Address	City /Town	Province	Postal Code
5805 WHITTLE ROAD, #101	MISSISSAUGA	ON	L4Z 2J1

Area Code Telephone Number	Area Code FAX Number	Description of Business Activity
(905) 507- 9707	(905 507-9712	Administrative office for temporary services

Worksite Location, Branch, Plant, Department Where Worker Employed: CANADIAN TIRE TRANSPORTATION (STORE IN ALDERSHORT, ONT)
Classification Unit Code See Instructions

Do you have an early return to work, Co-operative Return to Work program or an accommodation program in your workplace? ☒ no ☐ yes

Is the injured worker represented by a trade union? ☒ no ☐ yes

C. Temporary Disability

Following the day that the injury/awareness of disease occurred, will the injured worker be absent from work because of the injury/disease? ☐ unknown ☒ yes ☐ no

If you answered "no" to the above, will the injured worker as a result of the injury/disease:

- assume other work duties because the injury/disease prevents them from performing their regular duties? ☐ yes ☒ no
- earn less than their regular wages because of the injury/disease? ☐ yes ☒ no

Note: If your answer is "no" to all of these questions do not complete Section F, "Earnings Information".

D. Details of Injury/Disease

Date and Hour of Injury/ Awareness of Disease (day month year)	Date and Hour Reported to Employer (day month year)	Date and Hour Last Worked (day month year)	Normal Working Hours on Last Day Worked
06 FEB 1997 0845 a.m. ☐ p.m. ☐	06 FEB 1997 0845 a.m. ☐ p.m. ☐	06 FEB 1997 905 a.m. ☐ p.m. ☐	from 0700 2030

Date and Hour Returned to Work (day month year)	Actual Earnings for Last Day Worked	Normal Earnings for Last Day Worked	Do you have any information that the worker could have returned to work earlier? If so, provide details.
a.m. ☐ p.m. ☐	198.25	198.25	

1. What happened to cause the injury/disease? If known, describe injury, part of body involved and specify left or right side.
   STRUCK (BY) OBJECT, SPRAINS, STRAINS, NECK ~ head ~ back

2. Who was the injury/disease reported to? If injury/disease was not reported immediately, provide reason for delay.
   Reported to: MONIQUE RIVARD AT ACTION FORCE -

3. Describe the worker's activities at the time of the injury/disease. Include details of equipment or materials used and the size and weights of objects being handled.
   WHILE UNLOADING A TRUCK, A LOAD OF BOXES VARYING IN WEIGHT (6 GREY BINS/TOTES) FELL ON HIS BACK. WORKER STATED HE HURT HIS LOW, MID AND UPPER BACK AS WELL AS HIS NECK AND THE BACK OF HIS HEAD.

4. Where was the worker when the injury/awareness of disease occurred? If the injury/disease occurred outside of Ontario, specify province, state or country.
   CANADIAN TIRE TRANSPORTATION (STORE IN ALDERSHORT, ONT)

5. Is there anyone else who may have witnessed or who may know about the injury/onset of disease? If so, provide details below.
   Name(s) Address(es) and phone number(s) if available
   WITNESS: ANGES GILLON 905-684-4942

Confidential-Use for Workplace Insurance Purposes Only and Shred.

Workers' Compensation Board Ontario / Commission des accidents du travail

Employer's Report of Injury/Disease
Form 7 (Page 2)

WCB use only

Worker's Name: TAYLOR, PAUL

Social Insurance Number: [redacted]

Claim Number: [redacted]

E. Health Care

Did the worker receive health care? [X] yes [ ] no [ ] don't know

Initial or emergency health care: if known, provide the name and address of practitioner/facility.
UNKNOWN GOING TO DOCTR TODAY 1ST TIME (10FEB)

Current or continuing health care: if known, provide the name, address and telephone number of practitioner/facility, if different than above.
DR. SAULS - 905-820-8144 MISSISSAUGA.

F. Earnings Information - Do not complete this section if you answered "No" to all questions in Section C on page 1.

Rate of Pay (before tax)	Total Weekly Pay Hours	If weekly pay hours are irregular, please state average weekly hours.	Does the worker's work schedule change from week to week?
.15 [X] hourly [ ] daily	60.00		[X] yes [ ] no

From Revenue Canada TD1 provide: Net Claim for Exemption	Net Claim Code	Enter Worker's Usual Work Days (F = full day, H = half day)	S	M	T	W	T	F	S
6,456.00	01			F	F	F	F	F	

Are Benefit Plan (Health Care, Life Insurance, Pension) contributions continuing? [ ] yes [ ] no [X] not applicable

If "no", is the benefit plan a multi-employer benefit plan? [ ] yes [X] no

The worker also receives the following earnings in addition to the Rate of Pay as reported above. (Check all that apply.)

	Will this benefit continue while the worker is absent from work due to this injury/disease?	If "no", please state value if known
[X] Vacation Pay	[ ] yes [X] no	$ [ ] [ ]
[ ] Production Bonuses	[ ] yes [ ] no	$ [ ] daily [ ] weekly
[ ] Profit Sharing	[ ] yes [ ] no	$ [ ] daily [ ] weekly
[ ] Room and board and/or benefit from the worker's personal use of an employer's vehicle	[ ] yes [ ] no	$ [ ] daily [ ] weekly
[ ] Cost of living allowance, shift differential, lead hand premium	[ ] yes [ ] no	$ [ ] daily [ ] weekly
[ ] Tips and Gratuities	[ ] yes [ ] no	$ [ ] daily [ ] weekly
[ ] Unemployment insurance benefits paid in a job creation or work-sharing program	[ ] yes [ ] no	$ [ ] daily [ ] weekly

Identify Type of Employment (Check all that apply)
[ ] Full Time [ ] Part Time [ ] Casual [ ] Seasonal [ ] Apprentice [ ] Student [ ] Learner [ ] Other TEMPORARY

If the worker worked after the first absence, please enter dates. From day month year a.m. p.m. To day month year a.m. p.m.

G. Advances

If you have advanced or will be advancing anything to cover period of disability, give particulars including dates covered.

If advances are to be mailed to another address, please provide.

H. Claim Information

To your knowledge has the worker had a previous similar injury/disease? [X] no [ ] yes ??

If yes, provide details. If the previous similar injury/disease was work-related, include prior WCB claim number if known.

PROBABLY

Was any individual who does not work for you totally or partially responsible for the injury/disease? [X] no [ ] yes If yes, please explain.

If machinery, equipment or a motor vehicle was totally or partially responsible for the injury/disease, refer to the instructions on the reverse of the Employer's Copy and provide particulars.

Do you have any reason to doubt that the injury/disease is work-related? [X] no [ ] yes If yes, please explain.

Letter of explanation attached? [X] no [ ] yes

Who is responsible for arranging the worker's return to work? (Name and telephone number)
MONIQUE RIVARD, SERVICE COORDINATOR, ACTION FORCE TARGET OFFICE Phone: (416) 748-1667

I. It is an offence to deliberately make false statements to the WCB. I declare that all of the information provided on pages 1 and 2 of this report is true.

Name of Person Completing this Report: CHRIS PANCIW

Official Title: WCB Claims Administrator

Signature: C. Panciw

Area Code Telephone Number: 905 507-9707 ext 230

Date: 10 FEB 1997

WCB use only

Final	Pending	Lost Time	No Lost Time	Third Party	Out of Province

Signature: [signature] Date: FEB 11 1997. Paid From: [illegible] Paid To: [illegible] 2 DAYS

(0007A (11/95)) WCB COPY - WHITE WORKER COPY - PINK EMPLOYER COPY - YELLOW

Confidential-Use for Workplace Insurance Purposes Only and Shred.

Workers' Compensation Board / Commission des accidents du travail
Ontario

Ce formulaire est disponible en français sur demande.

025

2051879F-7

Employer's Report of Injury/Disease
Form 7

- Please read the instructions on the reverse of the Employer's Copy (yellow copy).
- Please type or print firmly in dark ink.
- Do not fold page 2 under page 1 when completing the form.

WCB use only
Claim Number

A. Worker Identification

Last Name: Taylor | First Name: Paul

Address: [redacted]

City /Town: [redacted]

Province: O[redacted]

Worker Reference Number | Miner's Certificate Number

Social Insurance Number: [redacted] | Years Experience in Occupation: 10

Occupation at Time of Injury/Awareness of Disease: Driver

Date of Birth: [redacted] | Sex: M | Date of Hire: day / month / year

Worker's Preferred Language of Service: [X] English [ ] French

Other language if worker speaks neither English/French

Is the injured person a (sub) contractor, independent operator, owner, executive of the business or spouse or relative of the employer? [ ] yes [X] no

Area Code Telephone Number: (905) 949-0637

B. Employer Identification

Employer Name: Action Force Driver Service | Firm Number | Rate Number

Address: 1790 Albion Rd | City /Town: Rexdale | Province: ONT. | Postal Code: M9W 4S8

Area Code Telephone Number: (416) 748-1667 | Area Code FAX Number: (416) 748 0780 | Description of Business Activity

Worksite Location, Branch, Plant, Department Where Worker Employed: Canadian Tire Transportation 2111 Steeles Ave W. Brampton ONT. | Classification Unit Code (See instructions)

Do you have an early return to work, Co-operative Return to Work program or an accommodation program in your workplace? [ ] no [ ] yes

Is the injured worker represented by a trade union? [ ] no [ ] yes

C. Temporary Disability

Following the day that the injury/awareness of disease occurred, will the injured worker be absent from work because of the injury/disease? [ ] unknown [X] yes [ ] no

If you answered "no" to the above, will the injured worker as a result of the injury/disease:

- assume other work duties because the injury/disease prevents them from performing their regular duties? [ ] yes [ ] no
- earn less than their regular wages because of the injury/disease? [ ] yes [ ] no

Note: If your answer is "no" to all of these questions do not complete Section F, 'Earnings Information'

D. Details of Injury/Disease

Date and Hour of Injury/ Awareness of Disease (day / month / year)	Date and Hour Reported to Employer	Date and Hour Last Worked	Normal Working Hours on Last Day Worked
6 / 2 / 97 — 9:45 am / pm	6 / 2 / 97 — am / pm	6 / 2 / 97 — 9:05 am / pm	from 7 AM to 8:30 pm

Date and Hour Returned to Work (day / month / year)	Actual Earnings for Last Day Worked	Normal Earnings for Last Day Worked	Do you have any information that the worker could have returned to work earlier? If so, provide details
am / pm	198.25	—	

1. What happened to cause the injury/disease? If known, describe injury, part of body involved and specify left or right side.
Load Fell on Driver when He was hand unloading on his back neck and head

2. Who was the injury/disease reported to? If injury/disease was not reported immediately, provide reason for delay.
Monique Rivard.

3. Describe the worker's activities at the time of the injury/disease. Include details of equipment or materials used and the size and weights of objects being handle
Driver was Hand unloading his load which consists of boxes that ~~weigh 50 lbs~~ 150 lbs - 300 lbs comb. weigh

4. Where was the worker when the injury/awareness of disease occurred? If the injury/disease occurred outside of Ontario, specify province, state or country
Inside his Trailer.

5. Is there anyone else who may have witnessed or who may know about the injury/onset of disease? If so, provide details below.

Name(s)	Address(es) and phone number(s) if available
Angnes Gillon	Aldershott ont 905-634-4442

1PAGE #: 1 TRIP MANIFEST TRIP NO. 97020502205
DRIVER: P. TAYLOR - CITYCLOCK#: 003021 TRACTOR: 000000 TRAILER: 87057
SCHEDULED DEPARTURE: 97/02/05

SPECIAL INSTRUCTIONS:

0220S ALDERSHOT, ONT*** OPEN 7:45 AM/ BILLS AT GATE BY 11:30PM ***
PICKUP AT 6204 TREBOR ALLAN HAMILTON 440 VICTORIA AVE. NORTH
(905) 529 7146 X285
*** #220575, 22SKIDS. BR ***
RETURN AT BMTN WHSE BRAMPTON 2111 STEELES AVE. E.
BRAMPTON ONT.
905-792-2244 OR
1-800-387-9045
IF YOU CAN'T MAKE A PICK UP PHONE TORONTO DISPATCH
**** COMPLETE SHIPPING MEMO FOR EACH PICKUP ****

	B/L	DESTINATION	PIECES	WEIGHT	INSTR.	EXCEP.
__	005245096	0220S ALDERSHOT, ONT.	273	4783	DP	
__	005245093	0027S DUNDAS, ONT.	738	12167	DP	
__	005245094	0045S HAMILTON, ONT.	353	4567	DP	
__	005245097	0702S HAMILTON, ONT.	60	1072	DP	
__	005245095	0129S HAMILTON CENTER	742	11065	DP	
__						
__						

Please note: 6 Totes and 10 cases of oil Fell on Driver's Back and Head. 9:45am ~~FEB~~ 6/97 aprox weight 150-200 lbs (dangers Loading)

PICK UP

	MEMO#	SHIPPER	PIECES	WEIGHT	INSTR.	EXCEP.
__		TREBOR ALLAN IN			PU	
__						
__						

RETURN TO WAREHOUSE 03 BMTN WHSE

__						
__						

---------- C O N ' T --------->

1PAGE #: 2 TRIP MANIFEST TRIP NO. 97020502205
DRIVER: P. TAYLOR - CITYCLOCK#: 003021 TRACTOR: 000000 TRAILER: 87057
SCHEDULED DEPARTURE: 97/02/05

__	TOTAL OUTGOING *****	2166	33654	

Confidential-Use for Workplace Insurance Purposes Only and Shred.

EMPLOYEE INCIDENT REPORT

A ☐ NO INJURY / hazardous situation

☐ INJURY / NO W.C.B. CLAIM ☐ first aid

W.C.B. CLAIM (WCB FORM 7) ☐ health care (medical aid) ☐ lost time

PART 1

Last Name	First Name	Sex	Marital Status	Area Code	Phone No.	Date of Birth
TAYLOR	PAUL	M	S	905	4490637	[redacted]

Address (no. street apt.) [redacted] | City/Town | Province | Postal Code | Department/Unit

Date of Employment (day / month / year)	Occupation at time of the injury and years of experience in that occupation	Years Exp	Language Spoken if not English	Social Insurance No.
16 / Mar / 95	Driver	10	Eng	[redacted]

PART 2

C DAY OF INCIDENT	TIME OF DAY	DAY REPORTED	TIME OF DAY
~~Feb~~ 6/97	8:45 AM	~~Feb~~ 6/97 ~~4:05 AM~~	9.05 AM

D STATE EXACTLY – WHAT WAS THE SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT, WHERE INCIDENT OCCURRED, WHAT EMPLOYEE WAS DOING, SIZE, WEIGHT AND TYPE OF EQUIPMENT OR MATERIALS INVOLVED, ETC

Was Hand unloading at a C.T.C. Store IN Aldershott ONT. when 6 grey Bins (Totes) Fell ~~DN~~ ON MY Back and Head (There was approx 10-15 cases of oil ~~th~~ behind the Grey Bins)

R. L. Taylor
SIGNATURE OF PERSON REPORTING INCIDENT

SIGNATURE OF DEPT HEAD OR SUPERVISOR

E TYPE OF INCIDENT (✓) — SEE DEFINITION ON REVERSE OF WHITE COPY

1 ☒ STRUCK OR CONTACT BY
2 ☐ STRUCK AGAINST / CONTACT WITH
3 ☐ CAUGHT IN, ON, OR BETWEEN
4 ☐ FALL
5 ☐ OVER EXERTION / STRAIN
6 ☐ EXPOSURE
7 ☐ PATIENT ACTION

F NAMES AND ADDRESSES OF WITNESSES OR PERSONS HAVING KNOWLEDGE OF THE INCIDENT

Angnes Gillien 905-634-4942 - Aldershott ONT.
905-637-5291

G WHAT CONDITIONS CONTRIBUTED TO THE INCIDENT (✓) (Number all contributing causes in order of importance)

1 ☐ OPERATING WITHOUT AUTHORITY	7 ☐ WORKING ON MOVING OR DANGEROUS EQUIPMENT	13 ☐ INADEQUATE ILLUMINATION
2 ☐ FAILURE TO SECURE OR WARN	8 ☐ DISTRACTING, TEASING, WILFUL MISCONDUCT	14 ☐ FIRE, EXPLOSION, ATMOSPHERIC HAZARD
3 ☐ WORKING AT UNSAFE SPEED	9 ☐ FAILURE TO USE PERSONAL PROTECTIVE DEVICES	15 ☐ HAZARDOUS PERSONAL ATTIRE
4 ☐ UNSAFE EQUIPMENT	10 ☐ WHEELED EQUIPMENT OPERATION	16 ☒ UNSAFE DESIGN OR ARRANGEMENT
5 ☒ UNSAFE LOADING, PLACING, MIXING, CONFINING, ETC	11 ☐ NOT GUARDED OR IMPROPERLY GUARDED	17 ☐ HAZARDOUS METHOD OR PROCEDURE
6 ☐ UNSAFE POSITION OR POSTURE	12 ☐ PATIENT ACTION	18 ☐ OUTSIDE HAZARDOUS CONDITION
		19 ☐ OTHER (explain)

EXPLANATION OF CAUSES: Load was Not SAFELY Loaded

DETAILS OF PROPERTY DAMAGE

H ACTIONS TO PREVENT INCIDENT RECURRENCE – MARK WITH (✓) THOSE ACTIONS TAKEN TO PREVENT RECURRENCE, MARK WITH (A) OTHER CORRECTIVE ACTIONS DECIDED UPON OR PLANNED BUT NOT YET CARRIED OUT. MORE THAN ONE ITEM MAY APPLY

1 ☐ REINSTRUCTION OF PERSON INVOLVED	5 ☐ ACTION TO IMPROVE INSPECTION	9 ☐ ACTIONS TO IMPROVE DESIGN / PROCEDURE
2 ☐ REASSIGNMENT OF PERSON	6 ☐ EQUIPMENT REPAIR OR REPLACEMENT	10 ☐ CHECK WITH MANUFACTURER
3 ☐ ORDER JOB SAFETY ANALYSIS DONE	7 ☐ CORRECTION OF CONGESTED AREA	11 ☐ INFORM ALL DEPARTMENT SUPERVISION
4 ☐ IMPROVED PERSONAL PROTECTIVE EQUIPMENT	8 ☐ INSTALLATION OF GUARD OR SAFETY DEVICE	12 ☐ DISCIPLINE OF PERSONS INVOLVED
		13 ☐ OTHER (explain)

DESCRIBE ACTIONS TAKEN TO PREVENT RECURRENCE

SIGNATURE OF DEPT HEAD OR SUPERVISOR

I DESCRIBE INJURY, PART OF BODY INVOLVED AND SPECIFY LEFT OR RIGHT SIDE

Lower-Mid and upper Back aswell as Neck and Back of Head.

NAME OF A) ATTENDING PHYSICIAN AND B) EMPLOYER'S PHYSICIAN

Dr R. Sauls 2300 Eglinton Ave W. Miss. ONT. 820-8144

TO YOUR KNOWLEDGE, HAS THE EMPLOYEE HAD A PREVIOUS SIMILAR DISABILITY? YES ☐ NO ☒

To be completed by Employee Health Service

VISITED EMPLOYEE HEALTH SERVICE YES ☐ NO ☒

IF YES THIS EMPLOYEE PROBABLY SHOULD

☐ UNDERTAKE REGULAR DUTIES ☐ MODIFIED DUTIES ☐ REMAIN OFF WORK FOR _____ DAYS

M. Rivard
SIGNATURE
Service Coordinator
POSITION

ACS AUTOMATION WCB CONSULTANTS

INJURY REPORTING FORM

Information to be used for work accident purposes only.

Employee's Name: Paul Taylor Employee No. 5822

Address: [redacted] Phone:

Location where accident occurred: Aldershot ONT Time: 8:45AM

Customer's Name: CANADIAN Tire STORE Inside Premises ☐

Address: Aldershot ONT Plains Rd. W. Outside Premises ☒

If other, explain: Outside ~~P~~premises Inside Other ☒
Trailer

Witness' Name: Angness Gillam Phone: 905-634-4947

PART OF BODY	HEAD	EYE ☐	TEETH ☐	FACE ☐	SKULL ☐	RIGHT ☐						
		EAR ☐	JAW ☐	NECK ☒	NOSE ☐	LEFT ☐						
	LIMBS	SHOULDER ☐	UPPER ARM ☐	ELBOW ☐	WRIST ☐	HAND ☐	FINGER ☐	RIGHT ☐				
		THIGH ☐	LOWER LEG ☐	KNEE ☐	ANKLE ☐	FOOT ☐		LEFT ☐				
	BODY	FRONT CHEST ☐	MID-BACK ☒	LOWER BACK ☒	RIGHT ☐							
		BACK CHEST ☐	STOMACH ☐	LOWER ABDOMEN ☐	LEFT ☐							
TYPE OF INJURY		CUT ☐	BRUISE ☐	DISCOMFORT/PAIN ☒	SHOCK ☐							
		BURN ☐	CRUSH ☐	FOREIGN BODY ☐								
CAUSE OF INJURY		STRUCK BY ☒	STRUCK AGAINST ☐	LIFTING OR PULLING ☐	IF OTHER, EXPLAIN							
		CAUGHT IN ☐	HANDLING MATERIAL ☐	FALL ☐	OTHER							

Further explanation: (your own words as to what happened) ~~was~~ was unloadi
when 6 grey bins (Totes) and aprox 10-15 cases of oil's Fell
on my Back - Neck - and Head

Was First Aid given: YES ☐ NO ☒ First Aider's Name:

Type of Treatment:

Was Record made: YES ☐ NO ☒

Action Force Branch TARGET