M.S.I.-1 **Worker's Claim**

Occupational Safety and Health

No lost time: ______

MSI use only
Claim #

WORKER INFO

Worker's Name ______ Today's Date: m/d/y ______

Address ______ RAMQ ______

______ SIN ______

Telephone ______ DOB ______

WHO IS YOUR EMPLOYER

Name: ______ Telephone ______

Address ______ FAX ______

Where at the employers did the event occur: ______

What is the injury? ______

Date of incident: m/d/y ______ Time: ______

Last date worked: m/d/y ______

Description of the event: ______

______

______

Were there any witnesses? Yes ☐ No ☐

If yes please list their names and telephone numbers

EMPLOYER COMPLETE THIS SECTION:

Worker Occupation: ______ Hourly Wages ______

Permanent/contract: ______ Hours per wk ______

Print employer contact name ______ Employer Signature ______

I declare that the information provided in this claim is true and complete Worker Signature ______

I authorize any physician or health professional, health worker, healthcare or social services institution or clinic to release information concerning my state of health to MSI for the purpose or processing my claim. Subject to express revocation, in writing by me. MSI reserves the right to access information from other agencies.

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