

Mail To:  
200 Front Street West  
Toronto ON M5V 3J1

OR Fax To:  
416-344-4684  
OR 1-888-313-7373

# 41 Worker's Progress Report (Form 41)

Claim Number	Desk No.	Alloc. No.
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Please PRINT in black ink

Worker's Name	Original Date of Accident/Injury	Injury
Accident Employer Name	If any information is incorrect, please provide the changes here:	

1. Please check which status best describes your current condition Describe any details or changes to your condition

Recovered     Getting Better  
 No Change     Getting Worse

2. Who is the primary health professional directing your current treatment?

Name \_\_\_\_\_ Date of last visit dd mm yy \_\_\_\_\_ Date of next visit dd mm yy \_\_\_\_\_

3. Please specify any referrals you have not yet reported to the WSIB

no new referrals     testing (e.g. labs, x-rays, CT Scan, MRI, etc.)     specialist     other (specify) \_\_\_\_\_

Name/Facility \_\_\_\_\_ Date of that appointment dd mm yy \_\_\_\_\_

4. Are you presently taking any drugs/medications or using an assistive device/brace for this injury?     yes     no  
If **yes**, list names \_\_\_\_\_

5. Have you worked for any employer(s) or were you self employed between the first day off and now?     yes     no  
If **yes**, provide details including dates, name/address of employer/company \_\_\_\_\_

6. Choose **one** of the following that best describes your **current** situation. **For this claim,**

I **have not** lost any time or pay from work (complete **only** question 7)  
 I **have** lost time and/or pay and **have** returned to work (complete **only** questions 7 and 8)  
 I **have** lost time and **have not** returned to work (complete **only** questions 9 to 12)

7. Was your return to work to a) <input type="checkbox"/> regular work <b>OR</b> <input type="checkbox"/> modified work b) <input type="checkbox"/> regular pay <b>OR</b> <input type="checkbox"/> lower pay c) <input type="checkbox"/> regular hours <b>OR</b> <input type="checkbox"/> less hours	8. Date of your return to work dd mm yy _____
9. Have you talked to your health professional about return to work? <input type="checkbox"/> yes <input type="checkbox"/> no If <b>yes</b> , date of last discussion dd mm yy _____ and have they determined your work limitations or functional abilities? <input type="checkbox"/> yes <input type="checkbox"/> no	10. Have you talked to your employer about return to work? <input type="checkbox"/> yes <input type="checkbox"/> no If <b>yes</b> , date of last discussion dd mm yy _____ name of person you talked to _____
11. Has any type of work been offered to you? <input type="checkbox"/> yes <input type="checkbox"/> no If <b>yes</b> , provide details _____	
12. Are there any other factors that are preventing you from returning to work? <input type="checkbox"/> yes <input type="checkbox"/> no If <b>yes</b> , provide details _____	

It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I declare that all of the information provided on this page is true.

Signature	Date dd/mm/yy
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