ACTIVEREHAB CENTRE

TEL: 416.321.3969
FAX: 416.321.6517
EMAIL: INFO@ARCENTRE.CA
WWW.ARCENTRE.CA
2240 MIDLAND AVE, UNIT 103-104
TORONTO, ONTARIO, M1P 4R8

WSIB INTAKE FORM

PATIENT INFORMATION

*Last name:	*First name:	Middle name:
Occupation:	Length of time at current job:	SIN:

ACCIDENT INFORMATION

*DOL:
(Date of accident)

Month: Date: Year:

*Please provide a brief description of how the accident occurred:

Are you currently receiving treatment from another health care professional?:

☐ No ☐ Yes – if yes, what?

_____

EMPLOYER INFORMATION

Employer:

Address:

12345 STREET ADDRESS UNIT # CITY PROVINCE POSTAL CODE

Supervisor Name:	Supervisor Phone no.:	Supervisor Fax no.:

AGREEMENT

The above information is true to the best of my knowledge. I acknowledge that any treatment fees not covered by WSIB will be my responsibility. I authorize Active Rehab Centre to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date