

## **Construction Exposure Incident Reporting (CEIR) Form**

The attached **Worker's Exposure Incident Reporting Form** (form 3885A 05/09) is intended for voluntary use when an unexpected workplace incident exposure has resulted from a leak, spill, rupture, unanticipated emission, explosion or a release of a dangerous chemical or physical substance or contact with an infectious substance or biological agent.

The purpose of this form is to obtain information about the exposure incident experienced by the worker should an illness or disease occur in the future.

This form should be completed by the worker who has experienced an unexpected exposure.

Employers complete an Employer's Exposure Incident Reporting Form (CEIR) (Form 3886A 05/09).

The **Worker's Exposure Incident Reporting Form** should only be completed if there has been an unexpected workplace exposure event where there has been:

- no lost time
- no illness

If you have experienced any illness needing medical treatment (*such as diagnostic tests, prescribed medication or ongoing treatment*) as a result of the incident, the employer should file an occupational disease claim using a Form 7. The worker should file an occupational disease claim using a Form 6.

Forms should be completed and given to your supervisor/Health and Safety Representative to forward to the WSIB. Completed forms can also be forwarded directly to the WSIB:

**By Mail**

Workplace Safety and Insurance Board  
CEIR Program  
200 Front Street West, 4<sup>th</sup> Floor  
Toronto, Ontario M5V 3J1

**By Fax**

416-344-5600  
1-888-313-7373

For questions concerning the Worker's Exposure Incident Reporting Form – CEIR, please contact us at:

Toll Free: 1-800-465-9646  
Local Dialing: 416-344-1010  
E-mail: CEIR\_project@wsib.on.ca  
Website: www.wsib.on.ca  
TTY: 1-800-387-0050

<b>WSIB Use Only</b>			
Firm No.	Rate No.	Classification Unit Code	Claim No.

**The following information will assist the Workplace Safety and Insurance Board (WSIB) in recording your workplace exposure incident. Please provide as much detail as possible to ensure that the incident is accurately recorded.**

<b>Your Information</b>			
Last Name	Given Name	Maiden Name (if applicable)	
Address (street address/city/town/province)			
			Postal Code
Telephone	Sex	<input type="checkbox"/> male <input type="checkbox"/> female	Date of Birth (dd/mm/yyyy)

<b>Your Employer's Information</b>			
Employer's Name (at time of incident)			Date of Hire (dd/mm/yyyy)
Describe the Nature of your Employer's Business		Your Occupation/Job Title	
Firm No.	Rate No.	Classification Unit Code	
Employer's Address for Correspondence (street address/city/town/province)			
			Postal Code
Location of Exposure Incident			
Does the project or workplace have a functioning Joint Health and Safety Committee (JHSC)?		Does the project or workplace have a Joint Health and Safety Representative?	
<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no	
If the answer is <b>yes</b> to either or both of the above questions, please attach the report of the Joint Health and Safety Committee or the Joint Health and Safety Representative.			
If the answer is <b>no</b> to the above questions, please attach the report of the exposed worker(s) if available.			
Are you a member of a union?		If yes, please provide your union name and local.	
<input type="checkbox"/> yes <input type="checkbox"/> no			

<b>Details of Incident</b>		
<b>If you experienced any illness related to this incident, please do not complete this form. Please complete a Worker's Report of Injury/Disease (Form 6). For further information, please contact 1-800-465-9646.</b>		
<b>Complete Section A</b> for an exposure to an infectious substance, or <b>Section B</b> for an exposure to chemical or other workplace substances.		
<b>Section A - Infectious Substances</b>	<b>Date of Exposure (dd/mm/yyyy)</b>	<b>Time of Exposure</b>
<b>What type of exposure was involved?</b> (please check):		
<input type="checkbox"/> cut or scrape <input type="checkbox"/> body fluid splash <input type="checkbox"/> cough, sneeze <input type="checkbox"/> other (please specify) _____		
Source of exposure	Area of Body Affected	
<b>What infectious substance is suspected?</b> (please check):		
<input type="checkbox"/> tuberculosis <input type="checkbox"/> meningitis <input type="checkbox"/> rabies <input type="checkbox"/> hepatitis <input type="checkbox"/> anthrax <input type="checkbox"/> campylobacter		
<input type="checkbox"/> salmonella <input type="checkbox"/> scabies <input type="checkbox"/> shingles <input type="checkbox"/> don't know <input type="checkbox"/> other (please specify) _____		

Claim No.
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**Details of Incident** ...(Continued)

<b>Section B - (Chemical or Other Workplace Substances)</b>	<b>Date of Exposure (dd/mm/yyyy)</b>	<b>Time of Exposure</b>
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**Please describe, in detail, what occurred:** (please check):

<input type="checkbox"/> leak	<input type="checkbox"/> rupture	<input type="checkbox"/> explosion
<input type="checkbox"/> spill	<input type="checkbox"/> unanticipated emission	<input type="checkbox"/> other (please specify) _____

What chemicals or workplace substances were you exposed to?

**Please describe where you were at the time of the exposure and how long you were in the affected area.**  
(If it would be helpful, attach a diagram to describe the event or another sheet for added information).


**What personal protective equipment were you wearing at the time?**


**In the event that this exposure results in an illness that entitles you to benefits under the Workplace Safety and Insurance Act (the Act), by signing this form, you consent to the release of functional abilities information as required in section 22(5) of the Act, in the event there is a right to benefits.**

Signature	Date
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**SUBMITTING THE EXPOSURE INCIDENT FORM TO THE WORKPLACE SAFETY AND INSURANCE BOARD**

If your employer is reporting the exposure you may provide this form to them to include with their submission. You may also choose to forward the form directly to the WSIB.

**By Mail**  
Workplace Safety and Insurance Board  
Construction Exposure Incident Reporting (CEIR) Program  
200 Front Street West, 4<sup>th</sup> Floor  
Toronto, Ontario M5V 3J1

**By Fax**  
416-344-5600  
1-888-313-7373

**Completing this form is voluntary. Your personal information is collected under the authority of the Workplace Safety and Insurance Act, 1997, S.O. 1997, c. 16, Schedule A, and will be used to record your unplanned exposure incident. This information may be disclosed for workplace health and safety and accident prevention purposes, as permitted by the Freedom of Information and Protection of Privacy Act. Questions about the collection of information should be directed to the Workplace Safety & Insurance Board, CEIR Program, 200 Front Street West, Toronto, Ontario, M5V 3J1. Please call: (416) 344-1010 or toll free 1-800-465-9646.**