



# Employer's Continuity Report

Employer
WCB Account Number
Address – <i>Include postal code</i>
Telephone – <i>Include area code</i>

**THE WORKER IS CLAIMING FURTHER ENTITLEMENT AS A RESULT OF THE INJURY SUSTAINED WHILE IN YOUR EMPLOY.**

**PLEASE ANSWER THE FOLLOWING QUESTIONS AND RETURN THE FORM TO OUR OFFICE SO THAT A DECISION MAY BE REACHED REGARDING THIS FILE.**

Worker	
WCB Claim Number	Date of Birth    YY   MM   DD
Injury	Social Insurance Number
Address	
Telephone	

In your observation, has the condition worsened over a period of time? If so please give specifics.


To your knowledge, has the worker complained about his/her condition to fellow workers? If so, please provide their names and addresses.


Following the original injury, was the worker in any way limited in performing his/her usual duties?


If another injury at work or elsewhere caused the symptoms to reappear, please provide details.


Signature	Date
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