



Worker's Continuity Report

Worker's <i>last name</i>	<i>first name</i>	FURTHER ENTITLEMENT OF THIS CLAIM WILL BE CONSIDERED WHEN YOU RETURN THIS FORM FULLY COMPLETED.
Postal address – <i>Include postal code</i>		
Residential Address	Employer	
Telephone – <i>Include area code</i>	Address – <i>Include postal code</i>	
WCB Claim Number		
Accident Date		
Adjudicator	Telephone – <i>Include area code</i>	

Your address, postal code and telephone number, if different from above	Your current employer's name, address, postal code and telephone number, if different from above

Describe your condition since your original injury

Dates and nature of medical treatment received since the original injury	Name, address and telephone number of the attending physician

IF YOU HAVE PURCHASED PRESCRIPTIONS THAT ARE RELATED TO THE ORIGINAL INJURY, PLEASE PROVIDE THE FOLLOWING:

Name, address and telephone number of physician	Name, address and telephone number of pharmacy	Name of prescription and dates purchased
Name	Name	Name Date YY MM DD
Address	Address	Name Date YY MM DD
Postal code	Postal code	Name Date YY MM DD
Telephone – include area code	Telephone – include area code	Name Date YY MM DD

If fellow workers or supervisors are aware of your continuing problems, please provide their names and addresses

Name	Name	Name
Address	Address	Address
Postal code	Postal code	Postal code

If a further incident aggravated your disability, please give details

Why do you feel your present condition is the result of your accident?

Please add any additional facts that may be helpful in establishing further entitlement

If you stopped work due to your disability, please provide dates

Signature	Date
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or

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