APPENDIX D
ACE INA Claims Form

Accident Report
Statement of Work Placement
Employer and Training Agency

ACE INA Insurance
130 King Street West
12th Floor
Toronto, Ontario M5X 1A6

SGC 102845

Name of Work Placement Employer _____

Name of Training Participant _____

Date Work Commenced _____, 20 _____

Is the Training Participant covered by the Workplace Safety Insurance Board Coverage? _____ Yes _____ No

Date last worked _____, 20_____

Reason Training Participant ceased work

_____

_____

_____

Description of accident:

_____

_____

_____

_____

Witness to accident: _____

If Training Participant has returned to work, give date of return _____ , 20_____

Describe exact duties of Training Participant prior to the date of accident or attach copy of job description

_____

_____

If Training Participant has returned to work, have you modified the duties due to the accident? _____Yes _____No
If "Yes", please describe

_____

_____

_____

Date _____ , 20_____

_____ _____
Name of Work Placement Employer's Authorized Representative (Please print) Signature

_____ _____
Name of Training Agency's Authorized Representative Signature