WAO INTAKE NOTES

Date:	Done by: By telephone ☐ In person ☐

Contact: ☐ First contact ☐ Repeat contact

Referred by: _____

Union: ☐ Yes ☐ No ☐ Not providing representation

A. WCB DECISION:

☐ Adj. ☐ CM ☐ RO ☐ AC ☐ ER appeal Date: _____

Reasons: _____ _____

_____ _____

_____ _____

B. CLAIMANT'S EXPECTATIONS:

☐ Acceptance of Claim: _____

☐ Wage Loss Benefits: from _____ until _____, or beyond _____

☐ Medical Aid Benefits: _____

☐ Other: _____

C. SUPPORT:

☐ Medical support from: _____

☐ Other evidence/explanation: _____

☐ None evident.

D. ACTION:

Claimant undertook to:

☐ Call back with details of WCB decision. ☐ Discuss decision with medical treatment provider.

☐ Provide new evidence to the WCB. ☐ Other: _____

WAO undertook to:

☐ Provide advice only. ☐ Provide referral to: _____

☐ Open file for review *(complete details below)*

Name:	Primary Phone No.:
Address:	Alt. Phone No.:
City, Province:	Email:
Postal Code:	WCB Claim No(s).:
Special Note:	Priority:

Notes:

_____

_____

_____ **Over**

Notes continued: