

Seven digit claim # (if available):

Claim Type	<input checked="checked" type="checkbox"/> 1 <input type="checkbox"/> Time lost <input type="checkbox"/> Modified work <input type="checkbox"/> Fatality Complete entire report if claim type is one of the above	<input type="checkbox"/> No time lost (Notice of non-disabling injury/illness) Complete all sections except for section 8, 9, 10 and 11
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Worker Details

Last name:		First name:		Initial:	
Mailing address: Apt# _____,			Social Insurance #:		
City:		Province:	Postal code:		Personal health #:
Phone number:			Date of birth: _____ <small>(Year / Month / Day)</small>		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X
Email address:					
Occupation:		Job description:		Date hired: _____ <small>(Year / Month / Day)</small>	
Does the worker have WCB personal coverage with this business? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is the worker a partner or director in this business? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the worker an apprentice? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date the worker would have obtained journeyman status: _____ <small>(Year / Month / Day)</small>			

Employer Details

Business name or government department:		WCB account number:		Industry: _____	
Mailing address:		2 Employer/Supervisor contact name and title:			
City:					
Province:		Postal code:		Contact phone:	
Phone:		Fax:		Contact e-mail:	

Accident Details

3	Date and time of accident: _____ <small>(Year / Month / Day)</small>	Time: ____:____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	or <input type="checkbox"/> the injury/condition developed over time
	Date and time scheduled shift started: _____ <small>(Year / Month / Day)</small>	Time: ____:____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
	Date and time scheduled shift ended: _____ <small>(Year / Month / Day)</small>	Time: ____:____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
4	Date accident/injury reported to employer: _____ <small>(Year / Month / Day)</small>		
To whom was the accident/injury reported?:		Phone number:	
5	Describe fully, based on the information you have, what happened to cause this injury or disease. Please describe what the worker was doing, including details about any tools, equipment, materials, etc., the worker was using. State any gas, chemicals or extreme temperatures worker may have been exposed to: _____ _____		
Motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If you have a police collision report, please mail or fax it to us once you have a claim number available. Please include the worker's name and claim number.		If you have more information, please attach a letter. Letter attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiac condition/injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did the accident/injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Location where the accident happened (address, general location or site):		
Were the worker's actions at the time of injury for the purpose of your business? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Were the actions part of the worker's regular duties? <input type="checkbox"/> Yes <input type="checkbox"/> No			



Worker's last name:	Worker's first name:	Initial:
Social Insurance #:	Date of birth:	<small>(Year / Month / Day)</small>

Accident Details (continued)

7 Do you have any concerns affecting the acceptance of this claim? If you need more space, please attach a letter. Yes No

Injury Details What part of body was injured? (hand, eye, back, lungs, etc.) Left side Right side

What type of injury is this? (sprain, strain, bruise, etc.)

8 Return to Work Details

I understand I have a duty to cooperate with WCB in coordinating a safe and healthy return to work for my injured worker.

a. Will/Did you pay the worker regular pay while off work? Yes No Has the worker returned to work? Yes No

b. Date worker first missed work: (Year / Month / Day)

c. If the worker has returned to work, indicate date: (Year / Month / Day)

Current work status: Regular work duties, or Modified work duties Regular hours of work, or Modified hours of work: ____ hrs per ____

Pre-accident rate of pay, or Revised rate of pay: \$ _____ per _____ Not working

d. Has modified work been offered? Yes No

Please describe the modified duties offered or currently performing:

Do you need assistance identifying modified work opportunities? Yes No

e. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? Yes No Was offered but the worker declined

f. Approximate return to work date: (Year / Month / Day)

9 Employment Type Details (Complete A or B or C. Select the worker's type of employment.)

A Permanent position employed 12 months of the year: Full time Part time Irregular/Casual

or **B** Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs): Seasonal worker Summer student Temporary

Position start date: (Year / Month / Day) Position end date: (Year / Month / Day) Estimated Actual

How many months or days per year do you employ workers in this position?

or **C** Alternate employment: Sub contractor Piece work Vehicle owner/operator Welder owner/operator

Self-employed Volunteer Commission Other

Does the worker incur expenses to perform the work (substantial materials, heavy equipment, larger tools, etc.)? Yes No

Will the worker receive a T4? Yes No

Please fill in your worker's name, Social Insurance Number and date of birth at the top of each page of the form in case the pages get separated.

Remember to complete all three pages and sign the form before sending.

Worker's last name:	Worker's first name:	Initial:
Social Insurance #:	Date of birth:	

10 Earnings Details Choose A or B:

Earnings information contact name (please print):

Earnings contact phone number: _____ Earnings contact e-mail: _____

A Gross earnings for the period of one year prior to the date of injury or date the worker was hired if less than one year: \$ _____ from: _____ (Year / Month / Day) to: _____ (Year / Month / Day)

Was any time missed from work **without pay** during the above period, excluding vacation? (eg. maternity, sick, WCB benefits) Yes No

Dates and reasons: _____

or B Worker's hourly rate of pay at time of accident: \$ _____

Additional taxable benefits:

Vacation pay Taken as time off with pay OR Paid on a regular basis % _____

Shift premium gross earnings: \$ _____ from: _____ (Year / Month / Day) to: _____ (Year / Month / Day)

Overtime gross earnings: \$ _____ from: _____ (Year / Month / Day) to: _____ (Year / Month / Day)

Other gross earnings: \$ _____ from: _____ (Year / Month / Day) to: _____ (Year / Month / Day)

11 Hours of Work Details

a. Number of hours (not including overtime): _____ per Day Week Shift cycle Other: _____

b. Does the work schedule repeat?
 No Yes →
 ↓
 Average regular hours worked per week (not including overtime):

Date shift cycle commenced: _____ (Year / Month / Day)

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>
Hours per day:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>
Hours per day:	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>

or if your schedule is more than 21 days, attach a copy of the schedule.

IMPORTANT
Circle day of injury. See instructions

Employer's signature: _____ Date: _____ (Year / Month / Day)

If you have any other information that would help us make a decision, or if you have concerns, please attach a letter.
THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH A DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW OR APPEAL.