



Employer's Initial Report of Injury

WCB Claim No.:

Section A: Employer Information

Name, address, postal code

Type of Business: _____
 Phone Number: _____
 Contact Person: _____
 E-mail: _____
 Fax Number: _____
 WCB Firm No.: _____ Industry Rate Code: _____

Section B: Worker Information

Name, address, postal code

Specific Division (if applicable): _____
 Occupation: _____
 Social Insurance Number: _____
 Personal Health Number: _____
 Birthdate: D M Y Sex: Male Female
 Hire Date: D M Y

Section C: Injury Information

- Injury date: D M Y
- Reported to employer on: D M Y
- Province of injury: _____
- Area of body injured: _____
- Name of healthcare provider: _____
- How did the injury happen? _____
- Has the employee lost time from work, due to the injury, after the day of injury? Yes; If "yes", go to question #8 No; If "no", go to Section E
- First day off due to this injury: D M Y Time the employee left work: _____ am pm
- Has employee returned to work? Yes No If "yes", what was the date employee returned: D M Y
- Do you have any reason to believe that this is not a work-related incident? Yes No If "yes", provide attachment(s) with explanation.

Section D: Wage and Employment Information

- How is the employee paid? If Regular Salary: Hourly \$ _____ per hour, _____ hours per week; If Monthly \$ _____ per month
 If Non-Regular: Piecework Sub-Contractor Owner / Operator Casual Other (explain) _____
- Provide gross earnings for the 12 months preceding first day off work due to injury, starting with the most recent *complete* pay period. If less than 12 months, show earnings for actual period: Gross earnings \$ _____ from D M Y to D M Y
- Time lost during the gross earning period due to: (a) Unpaid sickness _____ days; (b) Prior WCB claims _____ days; (c) Lack of work _____ days; (d) Other _____ days, explain _____
- Normal working hours for employee: From _____ am pm to _____ am pm Shift work involved Yes No
- Does the employee have regular days off? Yes No If "Yes", circle which days off: Sun Mon Tue Wed Thu Fri Sat
 If "No", circle the days off for the month of the injury, plus one month before and one month after first day off due to injury.
 MONTH BEFORE INJURY PERIOD 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
 MONTH OF THE INJURY _____ 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
 MONTH AFTER INJURY PERIOD 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
- TD1 Exemptions: Single Spouse, if partial provide: Provincial amount \$ _____ Federal amount \$ _____
 Other: \$ _____ No. Children 18 years or under _____
- Should compensation payments be made to: Employee, OR Employer? 18. Will employee be paid for statutory holidays? Yes No

Section E: Declaration I declare that all the information provided is true and correct to the best of my knowledge.

D M Y _____
 Date Name (please print) Title Signature