

# Worker's Initial Report of Injury WCB Claim No.: \_\_\_\_\_

## Section A: Worker Information

Name, address, postal code

Occupation: \_\_\_\_\_  
Social Insurance Number: \_\_\_\_\_  
Personal Health Number: \_\_\_\_\_  
Birthdate: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Sex:  Male  Female  
E-mail: \_\_\_\_\_

## Section B: Employer Information

Name, address, postal code

Employer contact person: \_\_\_\_\_  
Phone number of contact: \_\_\_\_\_

## Section C: Injury Information

- Injury date:          2. Reported to employer on:          3. Reported to: \_\_\_\_\_
- Province of injury: \_\_\_\_\_ 5. Area of body injured: \_\_\_\_\_
- How did the injury happen? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Name of healthcare provider: \_\_\_\_\_
- Name of hospital or clinic: \_\_\_\_\_
- Have you lost time from work, due to the injury, after the day of the injury?  Yes...If "yes" go to Section D  No...If "no" go to Section F

## Section D: Wage and Employment Information

- First day off due to this injury:          The time you left work: \_\_\_\_\_  am  pm
- Have you returned to work?  Yes  No If "yes"...enter the date you returned:
- How are you 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): \_\_\_\_\_
- If you have regular days off, circle which days: Sun Mon Tue Wed Thu Fri Sat
- Do you have other sources of employment income?  Yes  No If "yes"... attach employer names and phone numbers.
- Will you be paid by your employer for time loss due to the injury?  Yes  No

## Section E: Direct Deposit Information

If you wish to have compensation payments made directly to your bank account, please complete this section. Attach a personalized cheque or deposit slip marked "VOID". The Workers' Compensation Board is authorized to credit payments to your account with the financial institution you have named.

Bank or Financial Institution

Branch Address

City

Province

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

          
Date

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature