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WCB INJURY REPORT

INJURY INFORMATION (Please TYPE required information.)

To be completed by both the employer and the worker. If more space is needed, please attach additional pages, or use the space provided on page 3.

1. Please check one. The injury or illness occurred:

From a specific incident.

DATE (dd/mm/yyyy) TIME AM PM

Please complete questions 2 - 7.

Over a period of time.

Date symptoms first noticed: DATE (dd/mm/yyyy)

Please complete questions 2-12

5. Did the worker lose time because of this injury or illness? YES NO

If yes, give the date and time when time-loss started:

DATE (dd/mm/yyyy) TIME AM PM

Did the worker lose earnings because of this injury/illness? YES NO

If yes, give the date and time when earnings-loss started:

DATE (dd/mm/yyyy) TIME AM PM

Please complete page 3 if you answered yes to either of these questions.

2. What body part was injured?

Left side Right side Upper body Lower body

3. How did the injury(ies)/illness(es) happen? List any and all weights, distances, movements and equipment involved and the conditions or activity occurring at the time of the incident. If relevant, list exposures to noise or chemical agents, and the duration of the exposure.

Where did the injury(ies) occur? CITY/TOWN

COUNTY PROVINCE

If a person/factor, other than the employer/coworkers contributed to the cause of injury/illness, please explain:

6. Indicate if the worker is:

proprietor partner active officer or director of the company

Indicate if the worker is a family member living in the household of any proprietor/partner/active officer or director of the company. YES NO

7. To whom at your place of employment was the injury or illness reported?

NAME

TITLE () PHONE

Date reported: DATE (dd/mm/yyyy)

Please explain any delay in reporting:

OVER A PERIOD OF TIME SECTION

8. What are the worker's main job tasks?

9. Is the worker left or right hand dominant? LEFT RIGHT

10. How long has the worker been employed in this specific job/position?

If less than 90 days, in what job/position were they previously employed?

4. If medical attention was sought, please provide the name of the doctor OR medical facility where the worker was first seen. Also provide the date, phone number and location of the doctor OR medical facility.

Was medical attention sought? YES NO

NAME OF DOCTOR OR MEDICAL FACILITY

LOCATION

() PHONE DATE (dd/mm/yyyy)

11. How much overtime did the worker perform in the 90-180 days before this injury or illness occurred?

12. Have there been any changes in the worker's responsibilities in the past 90-180 days? (e.g. changes in duties, changes in workload, a leave of absence.) Please explain.

