

# EMPLOYER'S REPORT OF INJURY OR OCCUPATIONAL DISEASE

Please answer all questions and complete this report in ink. The *Workers Compensation Act* requires the employer complete and submit this report within **3 days** of a claimed injury, even if the employer is contesting the claim. Failure to do so is an offence and may result in the employer being charged with part of the cost of the claim. The Act requires the Board to collect detailed earnings information. **Please ensure that all information on this report is accurate, including the earnings data requested on the reverse side.**

**Please Note:**

**Facsimile (fax) copies are acceptable at all WCB offices in British Columbia.**

Registration number		Location		Classification Unit Number		Coded by		
<b>EMPLOYER'S NAME</b> (as registered with the Board)				<b>WORKER'S LAST NAME</b> (please print) Mr. Ms. Mrs. Miss				
Mailing address				First name(s)		Middle initial		
City		Postal code		Mailing address				
Location of plant or project where injury occurred		Postal code		City		Postal code		
Type of business		Employer's telephone number		Telephone number		Social insurance number	Weight	Height
Name of contact person in your firm		Worker's occupation		Worker's personal health number from BC CareCard				Date of birth
								Month Day Year

1. Date and time of injury 20 , at a.m./p.m.		8. Do you know of any previous pain or disability in the area of the worker's present injury? If YES, please explain. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
OR period of exposure resulting in occupational disease FROM 20 , TO 20		9. Do you know of any defect or disability the worker had prior to the injury (e.g. lost finger, blindness, deafness, etc.) If YES, please specify. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
2. Injury was first reported to employer TO <input type="checkbox"/> First Aid ON 20 , at <input type="checkbox"/> Supervisor a.m./p.m. or		10. Were there any witnesses? If YES, please give name and address. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
2A. Do you have any objections to the claim being accepted? If YES, please explain. If insufficient space, please attach a letter to this report. <input type="checkbox"/> YES <input type="checkbox"/> NO		10A. Do witnesses, if interviewed, confirm worker's statement? <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. Please describe fully what happened to cause the injury and mention all contributing factors: description of machinery, weight and size of objects involved, etc. OR 3A. In cases of occupational disease, describe when and how exposure occurred, mentioning any gases, vapours, dusts, chemicals, radiation, noise, source of infection or other causes. Please explain fully.		11. Please indicate worker's employment status: <input type="checkbox"/> Seasonal <input type="checkbox"/> Casual <input type="checkbox"/> Temporary <input type="checkbox"/> Part Time <input type="checkbox"/> Permanent, Full Time <input type="checkbox"/> Other (please provide details)	
4. Please state ALL injuries reported, indicating right or left if applicable.		12. Date worker started employment with you.	
5. Did worker receive first aid? If YES, please attach a copy of report 7A, First Aid Report. <input type="checkbox"/> YES <input type="checkbox"/> NO		13. Date worker started this job.	
6. Did worker attend a physician or qualified practitioner or clinic? If YES, please give name and address if known. <input type="checkbox"/> YES <input type="checkbox"/> NO		14. Were worker's actions at time of injury for the purpose of your business? If NO, please explain. <input type="checkbox"/> YES <input type="checkbox"/> NO	
7. Did worker go to a hospital? If YES, please give name of hospital. <input type="checkbox"/> YES <input type="checkbox"/> NO		15. Were they part of the worker's regular work? If NO, please explain. <input type="checkbox"/> YES <input type="checkbox"/> NO	

Questions 16 to 29 inclusive are on the reverse side of this report.

Worker's last name	First name	Middle initial	Social insurance number	Worker's claim number
				Worker's personal health number from BC CareCard

16. Does worker operate as a subcontractor? If YES, please provide details. <input type="checkbox"/> YES <input type="checkbox"/> NO	24. Will any payment be made to the worker by your firm for period of disability (other than day of injury)? If YES, please specify. <input type="checkbox"/> YES <input type="checkbox"/> NO																								
17. Is worker a relative of employer or a partner or principal of the firm? If YES, please specify. <input type="checkbox"/> YES <input type="checkbox"/> NO																									
18. Was any person not in your employ responsible for this injury? If YES, please give details and name and address of such person. <input type="checkbox"/> YES <input type="checkbox"/> NO	25. Wages paid on last day worked. \$																								
19. Is alternate light duty or modified work available? <input type="checkbox"/> YES <input type="checkbox"/> NO	26. Show normal work week by entering hours worked each day. If regular worker, fill out Week 1 only.																								
20. Will worker be off work beyond the day of injury? If YES, please complete questions 21 to 29 inclusive. <input type="checkbox"/> YES <input type="checkbox"/> NO	<table border="1"> <thead> <tr> <th></th> <th>Sun</th> <th>Mon</th> <th>Tues</th> <th>Wed</th> <th>Thur</th> <th>Fri</th> <th>Sat</th> </tr> </thead> <tbody> <tr> <td>Week 1 ▶</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Week 2 ▶</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Sun	Mon	Tues	Wed	Thur	Fri	Sat	Week 1 ▶								Week 2 ▶							
	Sun	Mon	Tues	Wed	Thur	Fri	Sat																		
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Week 2 ▶																									
21. Please be accurate in supplying wage information/worker's gross earnings at the time of injury (please enter one rate only). per hour \$      per day \$      per week \$      per month \$	Does the worker work a fixed shift rotation? If YES, please provide the details, including the shift rotation start date. <input type="checkbox"/> YES <input type="checkbox"/> NO																								
22. Worker's exact gross earnings for: 3 months \$ _____ prior to date of injury 1 year \$ _____																									
23. Are any of the following additions to regular wages: (please check appropriate box) <input type="checkbox"/> holiday pay <input type="checkbox"/> room and/or meals <input type="checkbox"/> rental <input type="checkbox"/> vehicle allowance <input type="checkbox"/> differential <input type="checkbox"/> equipment <input type="checkbox"/> shift premium <input type="checkbox"/> other If YES, please provide complete details.	27. Please enter hours on last day worked. FROM _____ a.m./p.m. TO _____ a.m./p.m.																								
Employer's signature	28. Date and time last worked after injury. 20 _____, at _____ a.m./p.m.																								
Title	29. Has employee returned to work? If YES, please specify date and time of return to work. <input type="checkbox"/> YES <input type="checkbox"/> NO 20 _____, at _____ a.m./p.m.																								
Date																									

"Personal information on this form is collected for the purposes of administering a worker's compensation claim by the Board in accordance with the **Workers Compensation Act** and the **Freedom of Information and Protection of Privacy Act**. For further information, please contact the Board's Freedom of Information Coordinator at 6951 Westminster Highway, Richmond, BC, V7C 1C6, or telephone 604 279-8171."

For additional information on the Workers' Compensation Board, please refer to our web site at [www.worksafefbc.com](http://www.worksafefbc.com)

**Mailing address** for report and all claims correspondence: Workers' Compensation Board of BC  
PO Box 8940 Stn Terminal  
Vancouver BC V6B 1H9  
Fax number: Local 604 233-9722 or toll free within BC 1 888 922-8803

**Telephone information**

Call the **Lower Mainland and Vancouver Island/Terrace** Call Centre at 604 231-8888 or toll free within BC 1 888 967-5377.

Call the **BC Interior and North** Call Centre at 250 717-4301 or toll free within BC 1 888 922-6622.

**Occupational Disease Services**, call 604 276-3007 or toll free within BC 1 888 967-5377 (extension 3007).

**Please Note:** If you have concerns with this claim, please contact the officer handling the claim at the WCB office to make known your objections or you may submit a letter detailing your specific concerns. OR

**Impartial Advice on WCB Claims** – To ensure you have an opportunity to obtain impartial advice on WCB claims matters, the BC legislature has provided impartial advisers. **Employers' Advisers** are available to provide independent advice or clarification on a WCB claim related to your firm. For additional information on the Employers' Advisers, please refer to their web site at [www.labour.gov.bc.ca/eao/](http://www.labour.gov.bc.ca/eao/).

Lower Mainland 604 713-0303 (Richmond) Toll free 1 800 925-2233	Kelowna 250 717-2050 1 866 855-7575	Prince George 250 565-4285 1 888 608-8882	Victoria 250 952-4821 1 800 663-8783
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