WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

REFERENCE GUIDE

Form 7 – Employer's Report of Injury or Occupational Disease

This guide has been created to assist employers when completing Form 7

Form 7		
Form Field Question	**Response Type**	**Description of Information Requested**
WorkSafeBC claim number	Alpha/numeric	This is the claim number assigned and provided to the injured worker, when their report of injury is received by WorkSafeBC
Employer's name (as registered with WorkSafeBC)	Text/numeric	The EXACT name of the Employer's firm as registered with WorkSafeBC.
Type of Business	Text	This refers to the nature of your business. E.g. logging, retail, hospital, etc.
WorkSafeBC account number	Numeric	The account number with which you are registered with WorkSafeBC. This used to be known as "firm number."
Classification unit number	Numeric	The classification unit number represents the specific industry in which your firm is operating and forms the basis of the assessment rate assigned.
Operating location number	Numeric	The operating location where the injury occurred.
Employer address line 1 (mailing)	Text/numeric	The address to receive correspondence regarding this claim.
Employer address line 2 (mailing)	Text/numeric	Additional mailing address line, if required.
City	Text	City for the mailing address provided.
Province/State	Text	Province or State in which mailing address is located.
Postal code/zip	Text/numeric	Postal Code or Zip Code for Employer's mailing address.
Country (if not Canada)	Text	This field only needs to be filled if the Employer's mailing address is outside of Canada.
Employer contact last name	Text	This is the name of the PRIMARY individual in your firm that WorkSafeBC should deal with regarding this claim.
First name	Text	As above.
Employer contact telephone (& area code)	Numeric	Business phone for person above
Extension	Numeric	Extension for business phone above, if applicable
Employer contact fax (& area code)	Numeric	Fax number for person above
Employer payroll contact last name	Text	Name of the person WorkSafeBC can contact regarding any earnings questions about the injured worker
First name	Text	As above
Employer payroll contact telephone (& area code)	Numeric	Business phone for person above.
Extension	Numeric	Extension for business phone above, if applicable.
Employer payroll contact fax (& area code)	Numeric	Fax number for person above.
Worker last name	Text	Surname of the injured worker.
First name	Text	First name of the injured worker.
Middle initial	Text	Middle initial of the injured worker.
Gender	Check box (x)	Select M or F.
Date of birth	Numeric	Date of birth of the injured worker.
Home phone number (& area code)	Numeric	Home phone number of the injured worker.
Social insurance number	Numeric	SIN number of the injured worker.
Address line 1	Text/numeric	Mailing address of the injured worker.
Address line 2	Text/numeric	Additional mailing address line, if required.
City	Text	City for injured worker's mailing address.
Province/state	Text	Province or State for injured worker's mailing address.
Country (if not Canada)	Text	Complete ONLY if worker's mailing address is outside of Canada.
Postal code/zip	Text/numeric	Postal Code or Zip Code for the injured worker's mailing address.
1. *What is the worker's occupation?*	Text	The worker's job (e.g. welder, nurse, bus driver, etc.) NOT their job title (e.g. Welder Supervisor; Senior Nurse Advisor III, etc.).
2. *Has the worker been employed by this firm for less than 12 months*	Check box (x)	This refers to less than 12 months *from the date of hire*.
3. *If yes, start date*	Numeric	Date worker was hired for this position.
4. ***At the time of the injury was the worker (check all that apply)*** - *Permanent* - *Temporary* - *Full time* - *Part time* - *Apprentice* - *Volunteer* - *Student* - *New entrance to workforce* - *Self employed* - *Principal/partner or relative of employer* - *Fisher* - *Hired on a contract basis* - *Casual* - *Other (please specify)*	Check box (x)	Please check all that are correct for the worker's position at the time the incident or exposure occurred.

5. Date and time of incident	Numeric	The exact date the incident occurred, and the approximate time of the incident, indicating am or pm.
6. Period of exposure resulting in occupational disease	Numeric	If applicable, indicate the period of time (from/to) that the exposure occurred.
7. Did worker report injury or exposure to employer?	Check box (x)	Please indicate "yes" or "no"
8. The injury or disease was first reported to employer on (yyyy-mm-dd. *TO: First aid; Supervisor, Office; Other*	Numeric, Check box (x), Text	Indicate the exact date the incident was reported to the employer. Select (x) who the incident was report to and if "other" provide a brief explanation.
9. Name of person reported to	Text	The name of the person to whom the incident was first reported. This could be the First Aid attendant, the employee's supervisor, manager, etc.
10. Describe how the incident happened	Text	A detailed explanation or description of *how* the incident occurred. Please indicate if employer observed the incident, or how you became aware of how the incident occurred.
11. Describe the injury in detail (what part of the body was injured)	Text	Provide a description of the *injuries*, clearly indicating which part(s) of the body were injured.
12. Side of body injured (left; right; both; not applicable)	Check box (x)	Indicate which side of the body was injured.
13. Describe the work incident location (address, city, province) and where the incident occurred (e.g. shop floor, lunchroom, parking lot)	Text	Please provide as much information about the incident location, including the exact work location to which the employee was assigned to work on date of injury, as well as the exact location within the worksite, where the incident occurred.
14. Did the injury(ies) or exposure result from a specific incident?	Check box (x)	Please indicate "yes" or "no"
15. ***Contributing factors – select AT LEAST ONE, and as many as applicable*** - *Lifting; _____lb. kg* - *Overexertion* - *Repetitive (activity repeated over and over again)* - *Slip or trip* - *Twist* - *Fall* - *Struck* - *Crush* - *Sharp edge* - *Fire or explosion* - *Harmful substance in the work environment* - *Animal bite* - *Assault* - *Motor vehicle accident* - *Unsure/other (please explain below)*	Check box (x)	Please select as many check boxes as applicable for the incident or exposure being reported.
16. Were there any witnesses?	Check box (x)	Please indicate "yes" or "no"
17. Did the incident occur in British Columbia?	Check box (x)	Please indicate "yes" or "no"
18. Were the worker's actions at time of injury for the purpose of your business?	Check box (x)	Please indicate "yes" or "no"
19. Did the incident occur on employer's premises or an authorized worksite?	Check box (x)	Please indicate "yes" or "no"
20. Did the incident happen during the worker's normal shift?	Check box (x)	Please indicate "yes" or "no"
21. Was the worker performing their regular duties at the time of the incident?	Check box (x)	Please indicate "yes" or "no"
22. Did the worker receive First Aid - *Date* - *If yes, please provide first aid attendant name (if known)*	Check box (x) Numeric Text	Please indicate "yes" or "no" Indicate date first aid provided to worker. If First Aid received, even if it did not occur at your place of employment, please provide the name of the attendant.
23. Did the worker to go hospital, clinic, or visit a physician or qualified practitioner? - *Date* - *If yes, please provide provider name (if known)*	Check box (x) Numeric Text	Please indicate "yes" or "no". It is helpful to have the Provider name, Clinic name or Hospital where worker was treated, so that appropriate medical forms can be obtained regarding injury or exposure.
24. Are you aware of any recent pain or disability in the area of the workers' reported injury?	Check box (x)	Please indicate "yes" or "no"
25. Do you have any objections to the claim being allowed?	Check box (x) Text	If you have any objections to this claim being allowed, please provide your reasons.
26. Did the worker miss any time from work beyond the date of injury or exposure?	Check box (x)	Please indicate "yes" or "no"
27. Provide the ***base salary*** *amount for this employment position at the time of injury*	Numeric	This refers to the base earnings the employee receives BEFORE any additional amounts of compensation earnings are provided, as outlined in question 28.
28. ***Does worker receive any other amounts of compensation in addition to base salary?*** *Does worker receive vacation pay on every*	Check box (x) Check box (x)	Please provide all types and amounts of compensation the employee receives in addition to the base salary.

cheque? *If yes, vacation pay %* *Please select check boxes for any of the following amounts worker receives in addition to base salary AND provide the amount for each* - *Shift differential* - *Room and board* - *Tips and gratuities* - *Overtime* - *Other*	 Numeric Check box (x) & Numeric	E.g. Shift premium might be an additional amount received for the type of job performed on a given shift. For example an employee may be acting as a first aid attendant, so an additional hourly amount would be paid. "Other" if another type of compensation is paid to an employee, please select "other" and provide brief explanation below that check box.
29. ***If worker is disabled from work, will you continue to pay:*** *Base salary?* *Other amounts of compensation in addition to base salary?* *Will worker receive vacation pay on every cheque?* *If yes, vacation pay %* *Please select check boxes for any of the following amounts worker will receive in addition to base salary AND provide the amount for each* - *Shift differential* - *Room and board* - *Tips and gratuities* - *Overtime* - *Other*	 Check box (x) Check box (x) Check box (x) Numeric Check box (x) & Numeric	Please provide all types and amounts of compensation the employee will continue to receive in addition to the base salary, if they are disabled from work. E.g. Shift premium might be an additional amount received for the type of job performed on a given shift. For example an employee may be acting as a first aid attendant, so an additional hourly amount would be paid. "Other" if another type of compensation is paid to an employee, please select "other" and provide brief explanation below that check box.
30. *Provide the amount of gross earnings for the past 3 months or 12 weeks prior to the date of injury or exposure.*	Numeric	Please provide the amount before deductions and include all other amounts of compensation, as outlined in question 28.
31. *Does the worker have a fixed shift rotation?*	Check box (x)	Please indicate "yes" or "no". If there is a shift pattern that repeats within 5 cycles or less, this is considered a fixed shift rotation. Some examples of a fixed shift rotation are: - 4 days on; 4 days off = 1 cycle - 8 hours/day Monday to Friday = 1 cycle
32. *If no, please explain.*	Text	If the employee's shift is not repeated within 5 cycles or less, please explain the shift rotation and cycles.
33. *If yes, show the normal work week by entering the paid hours*	Numeric	If yes to #30, please show the hours paid for one cycle on the one-week chart provided.
34. *Did the worker continue to work past day of injury?*	Check box (x)	Please indicate "yes" or "no".
35. *Last day worked.*	Numeric	Please provide the date the employee last worked; it may be the date of the incident; it may be a date later than the incident.
36. *Number of hour scheduled to work on last day worked?*	Numeric	How many hours was the employee scheduled to work on the last day they worked?
37. *Number of hours worked on last day*	Numeric	How many hours did the employee work on the last day they worked?
38. *Number of hours paid by employer on last day worked.*	Numeric	How many hours did you pay your employee for, on the last day they worked?
39. *Has the worker returned to work?*	Check box (x)	Please indicate "yes" or "no".
40 If YES: - *Date* - *Since the return to work, have the worker's duties, hours of work, work schedule and/or rate of pay changed?*	 Numeric Check box (x)	If yes, what was the date the employee returned to work? If yes, please indicate by selecting "yes" or "no", if any changes to the employee's duties, hours of work, work schedule and/or rate of pay have occurred.
41. If NO: - *Do you have any modified or transitional duties available* - *Have the modified or transitional duties been offered to the worker?*	 Check box (x) Check box (x)	 Please indicate "yes" or "no" If yes, was selected above please advise if those duties have been offered to the employee, by selecting "yes" or "no".
42. *If yes, please describe the modified or transitional duties.*	Text	Please explain how the duties have been modified in any way for the worker's return to work. This includes changes to hours per day, days per week, as well as the modification of tasks performed.
43. Employer signature	Text	Mandatory
44. Employer title	Text	Preferred
45. Date of report	Numeric	Mandatory