



Click on any field to start editing.

Employer's Initial Report of Injury

WCB Claim No: _____

Reporting Options: 1) WCB Teleservice 1.800.787.9288 2) WEB www.wcbask.com 3) Fax

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: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female

Hire Date: _____

Section C: Injury Information

1. Injury date: _____ Fatality? ☐ Yes ☐ No

2. Reported to employer on: _____ 3. Province of injury: _____

4. Area of body injured: _____

5. Name of healthcare provider: _____

6. How did the injury happen? _____

7. Has the employee lost time from work, due to the injury, after the day of injury? ☐ Yes ... go to question #8 ☐ No ... go to Section E

8. First day off and time employee left work due to this injury: Date: _____ Time: _____ ☐ a.m. ☐ p.m.

9. Has employee returned to work? ☐ Yes ☐ No If "yes", what was the date employee returned: _____

10. 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

11. How is the employee paid? If Regular Salary: Hourly \$ _____ per hour, _____ hours per week; If Monthly \$ _____

If Non-Regular: ☐ Piecework ☐ Sub Contractor ☐ Owner / Operator ☐ Casual ☐ Other (explain) _____

12. Provide gross earnings for the 12 months preceding first day off due to the work injury: \$ _____

If less than 12 months, provide gross earnings and time period: \$ _____ from _____ to _____

13. Time lost during the gross earnings period due to: (a) Unpaid sickness: _____ days; (b) Prior WCB Claims _____ days; (c) Lack of work: _____ days;

(d) Other _____ days (Explain): _____

14. Normal working hours for employee: From _____ ☐ a.m. ☐ p.m. To _____ ☐ a.m. ☐ p.m. Shift work involved ☐ Yes ☐ No

15. Does the employee have regular days off? ☐ Yes ☐ No If "Yes", mark which days off: Sun Mon Tue Wed Thu Fri Sat

If "No", mark 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 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 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

16. TD1 Exemptions: ☐ Single: ☐ Spouse, if partial: Provincial amount \$ _____ Federal amount \$ _____

☐ Other: \$ _____ Number of Children 18 years or under: _____

17. 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.

Please print & sign form before mailing/faxing.

Date _____

Name (please print) _____

Title _____

Signature _____