



Worker's Initial Report of Injury

WCB Claim No.:

Reporting Options: (1) WCB Telefile 1-800-787-9288 (2) WEB www.wcbask.com (3) Fax

Section A: Worker Information

Name, address, postal code

Occupation:

Social Insurance Number:

Personal Health Number:

Birthdate: Sex: Male Female

Home Phone:

E-mail:

Section B: Employer Information

Name, address, postal code

Employer contact person:

Phone number of contact:

Section C: Injury Information

1. Injury date: 2. Reported to employer on: 3. Reported to:

4. Province of injury: 5. Area of body injured:

6. How did the injury happen?

7. Name of healthcare provider: 8. Name of hospital or clinic:

9. 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

10. First day off and time you left work due to this injury: Date Time am pm

11. Have you returned to work? Yes No If "yes", enter the date and time: Date Time am pm

12. 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)

13. If you have regular days off circle which days: Sun Mon Tue Wed Thu Fri Sat

14. Do you have other sources of employment income? Yes No If "yes", attach employer names and phone numbers.

15. 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 Part 1 of this section and attach a personalized cheque or deposit slip marked "VOID" OR complete Part 2 from your cheque. The Workers' Compensation Board is authorized to credit payments to your account with the financial institution you have named.

Part 1

Bank or Financial Institution

Branch Address

City

Part 2

Table with 4 columns: Cheque Number (3-digit number), Transit Number (5-digit number), Bank Number (3-digit number), Account Number (Maximum 12-digit number). Includes a 'NOT REQUIRED' label for the first cell.

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