



SASKATCHEWAN
WORKERS'
COMPENSATION
BOARD

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Regina, Sask. S4P 4L1
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Worker's Progress Report

W3

Section A: Worker Address

Name, address, postal code

Phone Home: _____ Work: _____

Social Insurance Number: _____

Personal Health Number: _____

WCB Claim No.:

WCB Firm No: _____ Rate Code: _____

To complete the Form, please

1. Type or print using ink.
2. Be accurate and provide all information requested.
3. Complete Section D if you wish Direct Deposit payments.
4. Ensure you date and sign Section E.
5. Attach additional information, if relevant.
6. Mail OR fax report to WCB.
7. Contact the WCB if you have any questions.

Section B: Complete If You Have Returned to Work

1. When did you return to work?

Date: _____ Time: _____ a.m. p.m.
Day Month Year

2. Did you return to the employer shown in Section B on the W1?

Yes No, new employer information:

Firm Name: _____

Business Phone Number: _____

3. Are you doing the same job as before the injury? Yes No, explain:

4. Are you being paid the same amount as you were before your injury?

Yes No, explain: _____

5. Did you work between the day of injury and the day you returned to work?

No Yes, give dates

From: _____ Time: _____ a.m. p.m.
Day Month Year

To: _____ Time: _____ a.m. p.m.
Day Month Year

Section C: Complete If You Have NOT Returned to Work

1. Have you discussed a Return-to-Work plan with your employer? Yes No

2. When do you expect to return to work?

Date: _____ Time: _____ a.m. p.m.
Day Month Year

If you cannot provide this information, explain reason: _____

3. Who is providing medical treatment?

Name: _____

Last appointment: _____ Next appointment: _____
Day Month Year Day Month Year

Name: _____

Last appointment: _____ Next appointment: _____
Day Month Year Day Month Year

4. Have you worked between the day of injury and date of this report?

No Yes, give dates: Full Modified

From: _____ Time: _____ a.m. p.m.
Day Month Year

To: _____ Time: _____ a.m. p.m.
Day Month Year

5. Are you presently receiving disability benefits from the Canada Pension Plan Disability Program? If yes, please provide copy of initial acceptance letter.

No Yes, \$ _____ /month Effective Date: _____
Day Month Year

Section D: Direct Deposit Request (Attach a sample of your personalized cheque or deposit slip, marked VOID)

The Workers' Compensation Board is hereby authorized to credit payments to my account with the financial institution named. Should I change or close my account, I will immediately notify the Workers' Compensation Board to avoid delay in payment.

Bank or Financial Institution: _____

City: _____

Date: _____

Branch Address: _____

Province: _____

Signature: _____

Section E: Declaration

I declare all the information provided is true and correct. I understand that criminal prosecution may result from any attempt to obtain compensation benefits by fraudulent means.

Date: _____ Signature: _____