Saskatchewan Workers' Compensation Board

200-1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com

Phone: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free fax: 1.888.844.7773

Click on any field to start editing.

E1

Employer's Initial Report of Injury

WCB claim number: ____________

Reporting options: 1) Phone: 1.800.787.9288 2) www.wcbsask.com 3) Fax

Section A: Employer Information

Company name: ____________

Address: ____________

City: ____________ Prov: ______ Postal code: ______

Type of business: ____________

Phone: ____________ Fax: ____________

Contact person: ____________

Email: ____________

WCB firm number: ____________ Industry rate code: ____________

Section B: Worker Information

Name: ____________

Address: ____________

City: ____________ Prov: ______ Postal code: ______

Phone(s): ____________ / ____________

Specific division (if applicable): ____________

Occupation: ____________

Social Insurance Number ____________

Provincial Health Number: ____________

Date of birth: (MM/DD/YYYY) Gender: ☐ Male ☐ Female

Hire date: (MM/DD/YYYY)

Section C: Injury Information

1. Injury date: (MM/DD/YYYY) Fatality? ☐ Yes ☐ No
2. Reported to employer on: (MM/DD/YYYY) 3. Province of injury: ____________
4. Area of body injured: ____________
5. Name of health care provider: ____________
6. How did the injury happen? ____________
7. Has the worker 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 worker left work due to this injury: Date: (MM/DD/YYYY) Time: ______ ☐ a.m. ☐ p.m.
9. Has the worker returned to work? ☐ Yes ☐ No If "yes," what was the date the worker returned? (MM/DD/YYYY)
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 worker paid? If regular salary: Hourly $ ______ per hour, ______ hours per week; If monthly $ ______
    If non-regular: ☐ Piecework ☐ 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 (MM/DD/YYYY) to (MM/DD/YYYY)
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 the worker: From ______ ☐ a.m. ☐ p.m. To ______ ☐ a.m. ☐ p.m. Was there shift work involved? ☐ Yes ☐ No
15. Does the worker 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 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
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

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: ☐ Worker, OR ☐ Employer?

Section E: Declaration

I declare all the information provided is true and correct. I understand that criminal prosecution or penalties may result from any attempt to (1) obtain compensation benefits by fraudulent means and/or (2) prevent collection of compensation benefits.

(MM/DD/YYYY)			Please print & sign form before mailing/faxing.
Date	Name (please print)	Title	Signature