



Click on any field to start editing.

Employer's Progress Report

WCB Claim No: _____

Section A: Employer Information

Name, Address, Postal Code

Business Phone Number: _____

WCB Firm Number: _____ Rate Code: _____

To complete the form, please:

1. Type or print using ink.
2. Be accurate and provide all information requested.
3. Ensure you date and sign the declaration at bottom.
4. Attach additional information, if relevant.
5. Mail OR fax report to WCB, keep copy for your own records.
6. Contact the WCB if you have any questions.

Section B: Employee Information

Name, Address, Postal Code

Injury Date: _____
Day Month Year

Area of Injury: _____

Section C: Complete A or B

A. The Employee has Returned to Work

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

2. Is the employee doing the same job as before the injury?
 Yes No, explain:

3. Is the employee earning the same amount now as before the injury?
 Yes No, now earning \$ _____ (hour/week/month)

4. Did the employee work between the day of injury and the day they returned to work? No Yes, give dates:

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

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

5. Did you pay the employee anything for the period of work?
 Yes, amount \$ _____ No, reason: _____

B. The Employee has NOT Returned to Work

1. Have you discussed a Return-to-Work plan with this employee?
 No Yes

2. Is the employee expected to return to work? No Yes, when:
Date returned: _____ Time: _____ a.m. p.m.
Day Month Year

3. Will the return to work be: Full duties Modified duties, explain:

4. Will the return to work result in any wage loss?
 No Yes, amount \$ _____ explain: _____

5. Has the employee worked between the day of injury and the date of this report? No Yes, give dates:

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

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

6. Did you pay the employee anything for the period of work?
 Yes, amount \$ _____ No, reason: _____

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 (2) prevent collection of compensation benefits.

Date: _____ Title: _____ Signature _____ **Please print & sign form before mailing/faxing.**