wcb Saskatchewan Workers' Compensation Board
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E1

Click on any field to start editing.

Reset Form

Employer's initial report of injury

WCB claim number:

Reporting options: 1) Phone: 1.800.787.9288 2) WCB online account 3) Fax 1.888.844.7773 4) Email: forms@wcbsask.com

Has this incident already been reported to the WCB by the worker or a health-care provider? ☐ Yes ☐ No ☐ Unsure

Claim number (if known): _____

Is this injury related to a previous injury that has a past WCB claim? ☐ Yes ☐ No ☐ Unsure

Claim number (if known): _____

Section A: Employer information

Business name: _____

Address: _____

City: _____ Prov: _____ Postal code: _____

Phone: _____

WCB firm number: _____

Industry rate code: _____

Contact for general questions/inquiries

Contact person: _____

Phone: _____

Email: _____

Position: _____

Section B: Worker information

Name: _____

Address: _____

City: _____ Prov: _____ Postal code: _____

Email: _____

Phone(s): _____ / _____

Specific division (if applicable): _____

Occupation: _____

Social Insurance 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) 2. Fatality? ☐ Yes ☐ No

3. Reported to employer on: _____ (MM/DD/YYYY) 4. Province/State of injury: _____

5. Area of body injured: _____

6. In your own words, describe the incident as best you can: _____

7. Did the worker receive care from a health-care professional or visit a health-care facility due to this incident? ☐ Yes ☐ No ☐ Unsure

8. Do you have any reason to believe that this is not a work-related incident? ☐ Yes ☐ No

Explanation (if applicable): _____

9. Name of health-care provider or facility (if known): _____

10. Additional comments: _____

Section D: Wage and employment information

11. Has or will the worker miss time from work after the date of injury? ☐ Yes ☐ No ☐ Unsure

12. First day off and time worker left work due to this injury: Date: _____ (MM/DD/YYYY) Time: _____ ☐ a.m. ☐ p.m.

When writing to the WCB, please print name and claim or firm number.

13. After the day of injury, what was the next scheduled day the worker missed due to the injury? Date: _____ MM/DD/YYYY

14. Has the worker returned to work? ☐ Yes ☐ No ☐ Unsure

a. If yes, what day did the worker return to work? _____ MM/DD/YYYY

b. If yes, what is the number of calendar days between the date in Question 13 (include this day in your count) and Question 14.a.? _____

If this number is less than seven (7), please answer these questions:

i. How many days was the worker scheduled to work from the date in Question 13 (including the date in Question 13) plus the next six (6) calendar days? _____

ii. How many days did the worker miss in same period in 14.b., part i.? _____

15. Which best describes the worker's employment? ☐ Full time - hourly ☐ Full time - salary ☐ Part time - hourly ☐ Part time - salary ☐ Piecework ☐ Owner/operator ☐ Casual ☐ Other

16. What is the worker's gross (bi-weekly, monthly, annual) _____ salary? $ _____

If hourly paid, how many hours per week does the worker work? _____

If hourly paid, what is the worker's hourly wage? $ _____

17. What were the gross earnings for the worker from either the 52 weeks prior to the first day off due to injury or since the date of hire (if less than 52 weeks)?

$ _____

18. Date range for earnings _____ MM/DD/YYYY to _____ MM/DD/YYYY

19. Was the worker off work without pay at any time during the above gross earnings period? ☐ Yes ☐ No

If yes, how many total working days was the worker off without pay? _____

Comments (if applicable): _____

20. What was the reason for this unpaid time off? _____

21. TD1 exemptions: ☐ Single ☐ Spouse, if partial Provincial amount $ _____ Federal amount $ _____

☐ Other: $ _____ Number of children 18 years or under: _____

22. Who should receive wage-loss payments? ☐ Worker ☐ Employer

23. Additional comments: _____

Section E: Wage and employment contact

Name: _____ Phone: _____

Email: _____ Position: _____

Section F: 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.

Please print and sign form before mailing/faxing.

Date MM/DD/YYYY	Name (please print)	Title	Signature
_____	_____	_____	_____