

Click on any field to start editing.

# Worker's Initial Report of Injury

WCB claim number: \_\_\_\_\_

Reporting options: 1) WCB Teleservice 1.800.787.9288 2) www.wcsask.com 3) Fax

## Section A: Worker Information

Name, address, postal code	Occupation: _____
	Social Insurance Number: _____
	Provincial Health Number: _____
	Date of birth: _____ Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
	MM/DD/YYYY
	Phone: _____
	Do you require translation services? If yes, _____ language.
	Email: _____

## Section B: Employer Information

Name, address, postal code	WCB firm number: _____ Industry rate code: _____
	Employer contact person: _____
	Phone number of contact: _____

## Section C: Injury Information

1. Injury date: \_\_\_\_\_ 2. Reported to employer on: \_\_\_\_\_ 3. Reported to: \_\_\_\_\_  
MM/DD/YYYY MM/DD/YYYY

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

6. How did the injury happen? \_\_\_\_\_

7. Name of care 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 ... go to Section D  No ... go to Section F

## Section D: Wage and Employment Information

10. First day off work due to this injury: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
MM/DD/YYYY

11. Have you returned to work?  Yes  No If yes... enter the date and time: Date: \_\_\_\_\_  
MM/DD/YYYY

12. How are you paid? If regular salary: Hourly \$ \_\_\_\_\_ per hour \_\_\_\_\_ hours per week; If monthly \$ \_\_\_\_\_ per month  
If non-regular:  Piecework  Contractor  Owner / Operator  Casual  Other (explain) \_\_\_\_\_

13. If you have regular days off mark 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 your compensation payments made directly to your bank account, please choose one of the following options:

- Please attach a void cheque to this form (see example beside) and fax directly to the WCB at 1.888.844.7773, or mail to the WCB; OR
- Have someone from your bank complete, sign and stamp a bank deposit request form and fax directly to Finance or mail it to the WCB; OR
- If you need assistance, call 1.800.667.7590.

Name / Nom	<b>Example / Exemple</b>	Cheque No.	000000
P.O. Box / C.P. 000		N° de chèque	
City / Ville, Canada H0H 0H0			
Pay to the order of / Payez à l'ordre de	<i>"Void" &lt;&lt;Null&gt;&gt;</i>	\$ _____	Dollars
			Signature
9999    99999999 9999    9999 9999 99			

Please note: If you change or close your account, let the WCB know in writing to avoid any delay in payment.

## 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 & sign form before mailing/faxing.

Date MM/DD/YYYY

Name (please print)

Signature

