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) www.wcbsask.com 3) Fax 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: _____ Email: _____

Phone: _____ 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 injured 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.

MISSION: ZERO

13. Has the worker returned to work? ☐ Yes ☐ No ☐ Unsure If yes, when did the worker return to work? _____ MM/DD/YYYY

14. Was the return to work: ☐ Full duties ☐ Modified duties

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

Comments (if applicable): _____

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? _____

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

21. 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

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

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

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

24. 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 & sign form before mailing/faxing.

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