WORKSAFEBC

# Worker's Report of Injury or Occupational Disease to Employer

**▶ Submit directly to employer. Do NOT submit to WorkSafeBC.**

Section 53(3) of the *Workers Compensation Act* requires that, where a worker is fit, and on request of the employer, they must provide the employer with particulars of the injury or occupational disease on a report prescribed by WorkSafeBC and supplied to the worker by the employer. This is the report prescribed.

- If requested by employer, please complete this report as it appears.
- This report should be completed by the injured worker if fit to do so. It can be completed by another individual for signature by the injured worker.
- If you need assistance with completing this form, please call WorkSafeBC Claims Call Centre at 604.231.8888 or toll-free throughout Canada at 1.888.967.5377, Monday to Friday, 8 a.m. to 6 p.m. PST.

## Worker's information

| WorkSafeBC claim number (If known)<br>X | | Customer care number (If known)<br>X | |
|---|---|---|---|
| Worker's last name | | First name | Middle initial |
| Date of birth (yyyy-mm-dd)<br>\| \| \| \| - \| \| - \| \| | Personal health number (BC Services/CareCard)<br>\| \| \| \| \| \| \| \| \| \| | Social insurance number<br>\| \| \| \| \| \| \| \| \| | |
| Address line 1 | | Address line 2 | |
| City | Province/State | Country (If not Canada) | Postal code/Zip |
| Home phone number (include area code) | | Business phone number (include area code) | Business extension |
| Occupation | | | Gender<br>☐ Male ☐ Female |

## Employer's information

| Employer's organization name | | | |
|---|---|---|---|
| Type of business (If known) | | Operating location (If known) | |
| Address line 1 | | Address line 2 | |
| City | Province/State | Country (If not Canada) | Postal code/Zip |
| Employer's contact name | | Employer's phone number (include area code) | Extension |

## Incident information

| 1. Date and time of incident (yyyy-mm-dd)<br>☐ a.m. ☐ p.m. **OR** | 2. Period of exposure resulting in occupational disease (yyyy-mm-dd)<br>From To |
|---|---|
| 3. Date and time my injury or disease was first reported to my employer (yyyy-mm-dd)<br>☐ a.m. ☐ p.m. | My injury or disease was first reported to (please check one)<br>☐ First aid ☐ Supervisor ☐ Office ☐ Other (specify) |

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| Worker's last name | First name | Middle initial | WorkSafeBC claim number |
|---|---|---|---|
| | | | X |
| | Social insurance number | | Personal health number (BC Services card/CareCard) |
| | | | |

## Incident information (continued)

4. Name of person reported to

| 5. Did you receive first aid? ☐ Yes ☐ No ▶ | 6. Date of first aid (yyyy-mm-dd) | 7. Name of first aid attendant X |
|---|---|---|
| 8. Did you go to the hospital, a medical clinic, or see a physician? ☐ Yes ☐ No ▶ | 9. If yes, name of physician or provider (if known) X | |

10. Address of physician or provider (if known)

| 11. Are you aware of any recent pain or disability in the area of your reported injury? ☐ Yes ☐ No ▶ | If yes, please explain |
|---|---|

| 12. Was protective equipment being used? ☐ Yes ☐ No | 13. Were there any witnesses? ☐ Yes ☐ No |
|---|---|

14. The supervisor in charge at the time of my injury was

15. Describe how the incident happened

16. Describe the injury in detail (what part of the body was injured)

17. Side of body injured
☐ Left ☐ Right ☐ Both ☐ Not applicable

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| Worker's last name | First name | Middle initial | WorkSafeBC claim number<br>X |
|---|---|---|---|
| | Social insurance number | Personal health number (BC Services card/CareCard) | |

## Incident information (continued)

18. Describe the work incident location (address, city, province) and where incident occurred (e.g., shop floor, lunchroom, parking lot)

19. Contributing factors — select **at least one**, and as many as applicable

- ☐ Lifting _____ ☐ lb ☐ kg
- ☐ Overexertion
- ☐ Repetitive (activity repeated over and over again)
- ☐ Slip or trip
- ☐ Twist
- ☐ Fall
- ☐ Struck
- ☐ Crush
- ☐ Sharp edge
- ☐ Fire or explosion
- ☐ Harmful substance in the work environment
- ☐ Animal bite
- ☐ Assault
- ☐ Motor vehicle accident
- ☐ Unsure/other (please explain below)

20. Did you or will you miss any time from work beyond the date of injury or exposure?

☐ Yes ☐ No

## Signature and report date

| 21. Worker's signature | 22. Date of report (yyyy-mm-dd) |
|---|---|
| | |

## Additional information

The BC Legislature provides impartial advisers on all workers' compensation matters. The Workers' Advisers Office (WAO) provides free advice and assistance to workers and their dependants on disagreements they may have with WorkSafeBC decisions. WAO operates independently of WorkSafeBC. They have offices throughout the province and can be contacted at **http://gov.bc.ca/workersadvisers** or by telephone: Lower Mainland 604.713.0360, toll-free 1.800.663.4261; Vancouver Island 250.952.4393, toll-free 1.800.661.4066; Interior 250.717.2096, toll-free 1.800.663.6695.

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.