



This report must be completed in detail and forwarded after the first examination to WorkSafeBC

Please indicate your WORKSAFEBC VENDOR NUMBER in the space allotted at the bottom of this form.

To obtain your vendor number, please call: 604 231-8574 or toll-free: 1 888 422-2228, ext. 8574

**Mail** PO Box 4700 Stn Terminal  
Vancouver BC V6B 1J1

**Fax** 604 233-9777 or toll-free within BC 1 888 922-8807

**WorkSafeBC Call Centre** 604 231-8888 or toll-free within BC 1 888 967-5377

<b>Worker information</b>					WorkSafeBC claim number						
Title <i>Mr.</i> <input type="checkbox"/> <i>Mrs.</i> <input type="checkbox"/> <i>Dr.</i> <input type="checkbox"/> <i>Ms.</i> <input type="checkbox"/> <i>Miss</i> <input type="checkbox"/>		Worker last name			First name					Middle initial	
Address line 1					Address line 2						
City		Province/State		Country (if not Canada)			Postal code/Zip		Phone number (please include area code)		
Date of birth (yyyy-mm-dd)			Personal health number (BC Care card)					Social insurance number			

**Employer information**

Employer name (as registered with WorkSafeBC)				Employer phone number (please include area code)			
Address line 1				Address line 2			
City		Province/State		Country (if not Canada)		Postal code/Zip	

**Details of injury**

Employer's type of business			Date of injury (yyyy-mm-dd)			Location of plant or project where injury occurred																																																										
1. Please state condition of teeth or soft tissue <b>unrelated</b> to this injury (e.g. perio disease, gingival recession, etc.) (pre-existing condition)										2. Date first treated for injury (yyyy-mm-dd)																																																						
3. <b>ALL OF THE FOLLOWING ITEMS MUST BE COMPLETED.</b>			<table border="1"> <thead> <tr> <th>1.8</th><th>1.7</th><th>1.6</th><th>1.5</th><th>1.4</th><th>1.3</th><th>1.2</th><th>1.1</th><th>2.1</th><th>2.2</th><th>2.3</th><th>2.4</th><th>2.5</th><th>2.6</th><th>2.7</th><th>2.8</th> </tr> </thead> <tbody> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>														1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8																																
1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8																																																	
- Mark teeth injured "A". - Mark the teeth to be extracted "X". - Draw a line through the teeth missing prior to the injury.																																																																
4. Side of body injured L <input type="checkbox"/> R <input type="checkbox"/> Bilateral <input type="checkbox"/> Not applicable <input type="checkbox"/>																																																																
5. Please describe the extent of hard and soft tissue damage caused by this injury (diagnosis).																																																																
6. Were any temporary procedures related to the injury carried out? If so, please state teeth and code numbers.										7. Check this box if the injury resulted from a specific incident <input type="checkbox"/>																																																						
Please itemize treatment needed on a "STANDARD dental claim form" using British Columbia Dental Association (BCDA) fee guide CODES. Please clearly indicate on the "STANDARD DENTAL CLAIM FORM" whether your request is "FOR PRE-AUTHORIZATION" or "FOR PAYMENT."																																																																
(Stamp or type name, address, and postal code of treating dentist and personally sign.)				Phone number (please include area code)				WorkSafeBC vendor number																																																								
				Fax number (please include area code)				Date of service (date of examination) (yyyy-mm-dd)																																																								
				Signature of dentist				Date of report (yyyy-mm-dd)																																																								





			WorkSafeBC claim number			
Title <i>Mr.</i> <input type="checkbox"/> <i>Mrs.</i> <input type="checkbox"/> <i>Dr.</i> <input type="checkbox"/> <i>Ms.</i> <input type="checkbox"/> <i>Miss</i> <input type="checkbox"/>		Worker last name		First name		Middle initial
Date of birth (yyyy-mm-dd)		Personal health number (BC CareCard)			Social insurance number	

**Additional information**

Visit our web site at [WorkSafeBC.com](http://WorkSafeBC.com)

This report must be completed in detail and forwarded after the first examination to WorkSafeBC.

Please ensure you have included your **WorkSafeBC vendor number** in the space allotted at the bottom of page 1 of this form.

**Other assistance**

The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. The Workers' Advisers have offices throughout the province and can be contacted at [www.labour.gov.bc.ca/wab/](http://www.labour.gov.bc.ca/wab/)

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.