



As an employer (master/owner), the *Workers Compensation Act* requires you to submit this report **within three days** of an injury to one of your workers, even if you disagree with the claim. By submitting your report promptly, you avoid penalties and delays in the adjudication of the claim. Clearly PRINT details, sign the form, and submit it by **FAX** or **MAIL**. The *Workers Compensation Act* requires that an employer (master/owner) complete and submit a Fishing Incident Investigation Report, in addition to form 7F. For additional information on your reporting responsibilities, go to **WorkSafeBC.com**.

CLAIMS CALL CENTRE

Phone 604 231-8888
Toll-free 1 888 967-5377
M–F, 8:00 a.m. to 4:30 p.m.

FAX

604 233-9777
Toll-free 1 888 922-8807

MAIL

WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

WorkSafeBC claim number

Vessel master/owner information

Vessel master/owner's name			
Address line 1		Address line 2	
City	Province/state	Country (if not Canada)	Postal code/zip
Vessel master/owner phone (please include area code)		Extension	Vessel master/owner fax (please include area code)
Type of fishery at time of incident		Vessel name	
Trawl (702009) <input type="checkbox"/> Packer (702010) <input type="checkbox"/> Dive (702005) <input type="checkbox"/> Gillnet/troll (702006) <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Seine (702008) <input type="checkbox"/> Longline/trap (702007) <input type="checkbox"/>			
Is there another contact for documentation of earnings (accountant, settlement service, etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, earnings contact last name	
Earnings contact phone (please include area code)		Earnings contact extension	Earnings contact fax (please include area code)
		Earnings contact first name	

Worker information

Worker last name		First name		Middle initial	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Date of birth (yyyy-mm-dd)		Home phone number (please include area code)		Social insurance number	
Business phone number (please include area code)		Business extension	Address line 1		
Address line 2		City	Province/state	Country (if not Canada)	Postal code/zip

1. At the time of injury, was the worker (please check all that apply)					
Fisher <input type="checkbox"/>	Full time <input type="checkbox"/>	New entrant to workforce <input type="checkbox"/>	Self-employed <input type="checkbox"/>	Other (please specify) <input type="checkbox"/>	
Permanent <input type="checkbox"/>	Part time <input type="checkbox"/>	Principal/partner or relative of employer <input type="checkbox"/>	Casual <input type="checkbox"/>		
Temporary <input type="checkbox"/>	Student <input type="checkbox"/>	Hired on a contract basis <input type="checkbox"/>			
2. Does worker need an interpreter? Yes <input type="checkbox"/> No <input type="checkbox"/>		3. Preferred language		4. Dominant hand Left <input type="checkbox"/> Right <input type="checkbox"/>	
5. Worker's occupation (skiffman, diver, deckhand, etc.)					

Incident information

6. Date and time of incident (yyyy-mm-dd)		7. Period of exposure resulting in occupational disease (yyyy-mm-dd)	
		From To	
8. Describe how the incident happened		9. Describe the injury in detail (what part of the body was injured)	
10. Did the injury(ies) or exposure result from a specific incident? Yes <input type="checkbox"/> No <input type="checkbox"/>		11. Side of body injured Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable <input type="checkbox"/>	
12. Describe the work incident location (city or nearest port location) and where incident occurred (e.g. bow, stern, galley, skiff, dock, etc.)			



Employer's Report of Injury or Occupational Disease — Fishing *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number
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13. Contributing factors — select AT LEAST ONE, and as many as applicable

Lifting <input type="checkbox"/>	_____ lb <input type="checkbox"/> kg <input type="checkbox"/>	Animal bite <input type="checkbox"/>
Overexertion <input type="checkbox"/>	Struck <input type="checkbox"/>	Assault <input type="checkbox"/>
Repetitive (<i>activity repeated over and over again</i>) <input type="checkbox"/>	Crush <input type="checkbox"/>	Motor vehicle accident <input type="checkbox"/>
Slip or trip <input type="checkbox"/>	Sharp edge/Puncture <input type="checkbox"/>	Unsure/other (<i>please explain below</i>) <input type="checkbox"/>
Twist <input type="checkbox"/>	Fire or explosion <input type="checkbox"/>	
Fall <input type="checkbox"/>	Harmful substance in the work environment <input type="checkbox"/>	

14. Did worker report injury or exposure to vessel master? Yes <input type="checkbox"/> No <input type="checkbox"/>	15. If yes, date reported to vessel master (yyyy-mm-dd)	16. Name of person reported to
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17. Are you aware of any recent pain or disability in the area of the worker's reported injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please explain If yes, _____
18. Did the worker receive first aid? If yes, please provide: First aid attendant name (<i>if known</i>) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Date (yyyy-mm-dd) _____
19. Did the worker go to hospital, clinic, or visit a physician or qualified practitioner? If yes, please provide: Provider name (<i>if known</i>) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Date (yyyy-mm-dd) _____ Provider address (<i>if known</i>) _____

20. Do you have any objections to the claim being allowed? (*if yes, please explain*)
Yes No

Wage information

21. Did the worker miss any time from work beyond the date of injury or exposure? Yes No **If NO WORK MISSED AND NO CHANGE TO DUTIES OR PAY, proceed to the bottom of the page to sign, date, and submit this report. If WORK WAS MISSED, please answer ALL questions on this form.**

22. In the year prior to injury, please provide the periods of time the worker was employed by you From _____ To _____ From _____ To _____ From _____ To _____	23. Expected duration of the job/season/period of work
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24. Does worker own the vessel? Yes <input type="checkbox"/> No <input type="checkbox"/>	25. Does worker receive a share of the catch? Yes <input type="checkbox"/> No <input type="checkbox"/>	26. Please provide worker's gross earnings for one year prior to the date of injury \$ _____
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Return-to-work information

27. Has the worker returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/>	28. If YES: Date returned to work (yyyy-mm-dd) Since the return to work, has there been any change to the work duties or will there be any change to the hours of work, the work schedule, and/or the rate of pay? Yes <input type="checkbox"/> No <input type="checkbox"/>
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29. If NO: Are there any modified or transitional duties available? Yes <input type="checkbox"/> No <input type="checkbox"/> Have the modified or transitional duties been offered to the worker? Yes <input type="checkbox"/> No <input type="checkbox"/>	30. If yes, please describe the modified or transitional duties
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Fish buyer/processor information

31. Fish buyer/processor legal name	32. Employer account number	33. Classification unit number
34. Address line 1	35. Address line 2	
36. City	37. Province/state	38. Country (<i>if not Canada</i>)
		39. Postal code/zip
40. Fish buyer/processor phone (<i>please include area code</i>)	41. Fish buyer/processor extension	42. Fish buyer/processor fax (<i>please include area code</i>)

Signature and report date

Please sign and submit this form to WorkSafeBC and the fish buyer immediately.

43. Vessel master/owner's name (<i>please print</i>)	44. Vessel master/owner's signature	45. Date of report (yyyy-mm-dd)
46. Fish buyer/processor contact name (<i>please print</i>)	47. Fish buyer/processor contact signature	48. Date (yyyy-mm-dd)

For personal assistance, please call our Claims Call Centre at 604 231-8888 or toll-free within BC at 1 888 967-5377.
Please note: If you have concerns with this claim, please contact the officer handling the claim at the WorkSafeBC office to make known your objections or you may submit a letter detailing your specific concerns.
Impartial advice on WorkSafeBC claims — To ensure you have an opportunity to obtain impartial advice on WorkSafeBC claims matters, the BC legislature has provided impartial advisers. **Employers' Advisers** are available to provide independent advice or clarification on a WorkSafeBC claim related to your firm. For additional information on the Employers' Advisers, please refer to their web site at www.labour.gov.bc.ca/eaof/.

Lower Mainland 604 713-0303 (Richmond) Toll free 1 800 925-2233	Kelowna 250 717-2050 1 866 855-7575	Prince George 250 565-4285 1 888 608-8882	Victoria 250 952-4821 1 800 663-8783
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