

SELECT ONE ONLY: <input type="checkbox"/> Physician's First Report (F8) <i>(required if you suspect the worker may be disabled beyond the day of injury or if the claim is for a hernia, back condition, shoulder or knee strain/sprain, or occupational disease)</i>	<input type="checkbox"/> The worker's condition or treatment has changed (F11) <i>(required if the worker's condition or treatment has changed since last report or if the worker is ready for Return to Work)</i>
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Date of service (yyyy/mm/dd) / /	Date of birth (yyyy/mm/dd) / /	WorkSafeBC (WCB) claim number
Employer's name	Worker's last name	
Employer's telephone number <i>(must include area code)</i> () -	First name	Middle initial Gender
Operating location address	Mailing address <i>(include postal code)</i>	
Date of injury or when patient was first treated for this condition (yyyy/mm/dd) / /	Worker's contact telephone number <i>(must include area code)</i> () -	
Who rendered first treatment?	Worker's personal health number from BC CareCard	
Are you the worker's regular practitioner? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If YES, how long has the worker been your patient? <input type="checkbox"/> 0-6 months <input type="checkbox"/> 7-12 months <input type="checkbox"/> > 1 year		
Are there prior or other problems affecting injury, recovery, and disability?		
From injury or last report, has the worker been disabled from work? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, as of what date? (yyyy/mm/dd)		

8 / 11

Injury codes and descriptions

Diagnosis <i>(text)</i>		
CSA BP/AP <i>(code)</i>	CSA NOI <i>(code)</i>	ICD9 <i>(code)</i>

Clinical information

What happened? Subjective Sx, examination, investigations, treatments/meds, specialists consult?
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Return-to-work planning

Is the worker now medically capable of working full duties, full time? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If NO, what are the current physical and/or psychological restrictions?	
Estimated time before the worker will be able to return to the workplace in any capacity	
<input type="checkbox"/> Currently at work <input type="checkbox"/> 1-6 days <input type="checkbox"/> 7-13 days <input type="checkbox"/> 14-20 days <input type="checkbox"/> > 20 days	
If appropriate, is the worker now ready for a rehabilitation program? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, select <input type="checkbox"/> WCP or <input type="checkbox"/> Other	
Do you wish to consult with a WorkSafeBC physician or nurse advisor? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If possible, please estimate date of maximal medical recovery <i>(full recovery or best possible recovery yyyy/mm/dd)</i>	

Payee number	Practitioner number
Payee name	Practitioner name

➡ **Additional information can be recorded on form 8/11 ADDENDUM, Practitioner's Report/Additional Information**



The *Workers Compensation Act* requires that the *Physician's First Report*, containing all the information requested, shall be furnished to WorkSafeBC (the Workers' Compensation Board) within **3 days** after the date of first attendance to the worker.

Practitioner — This report needs to be completed and submitted only when, in the case of a First Report (F8):

1. You suspect the worker may be disabled beyond the day of injury
2. If the claim is for a hernia, back condition, shoulder or knee strain/sprain, or occupational disease
3. If none of the above criteria apply and WorkSafeBC requests this report (bill fee item 19927)
4. If a First Report should have been sent by #1 and 2 being met but was not, send the report and bill a fee item 19900

In the case of a follow-up visit, submit only (F11):

1. If the worker's condition or treatment has changed since the last report or if the worker is ready for Return to Work
2. It is not necessary to answer the following questions if completing a report for a follow-up visit (F11)
 - Are you the worker's regular physician? If YES, how long has the worker been your patient?
 - Who rendered first treatment?

IN ALL OTHER CASES, ONLY YOUR PRACTITIONER ACCOUNT FOR PROCEDURES OR VISIT IS REQUIRED.

Completed Practitioner Reports (paper versions) should be sent by facsimile (fax) to:

Lower Mainland	Fax 604 233-9777
Toll Free	Fax 1 888 922-8807

or by mail to:

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

For claim/claimant inquiries, contact:

Call Centre	604 231-8888 or toll free 1 888 967-5377
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For invoice inquiries, contact Payment Services:

Lower Mainland	604 276-3085
Toll Free	1 888 422-2228

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.

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Physician Office Use Only
