



Please answer all questions. If completing by hand, use **INK**

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

Worker information

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				Preferred first name			
Address line 2				Phone number <i>(please include area code)</i>			
City			Postal code/zip		E-mail address		
Date of birth <i>(yyyy-mm-dd)</i>			Personal health number <i>(BC care card)</i>			Social insurance number	

Employer information

Employer name <i>(as registered with WorkSafeBC)</i>		Phone number <i>(please include area code)</i>	
Address line 1		City	Province/state
		Postal code/zip	

Details of injury

Worker's occupation		Date of injury <i>(yyyy-mm-dd)</i>		Location of plant or project where injury occurred		Postal code/zip	
1. Date worker was first laid off work <i>(yyyy-mm-dd)</i>		Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		2. Has worker returned to work? <i>If yes, what date? (yyyy-mm-dd)</i>		Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
3. Did this employee work between first time off and final return or recovery? yes <input type="checkbox"/> no <input type="checkbox"/>				If yes, please give dates. <i>(yyyy-mm-dd)</i> from to			
4. Did worker return to work as soon as possible? <i>(please give your opinion)</i>							
or							
4A. If not returned to work, is the worker able to do so? <i>(please give your opinion)</i>							
5. On what date do you consider the worker was first able to return to work? <i>(yyyy-mm-dd)</i>						Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
6. How many working days or shifts did the worker miss? days <input type="checkbox"/> shifts <input type="checkbox"/>			7. Is the worker earning or able to earn as much as before the injury? yes <input type="checkbox"/> no <input type="checkbox"/>			Now earning <i>(\$ per week)</i>	
8. If not, how much has the injury reduced the earnings? <i>(\$ per week)</i>				9. How long is this impairment of earning capacity likely to continue?			
10. Have you paid or allowed the worker anything for the period of disability? If so, please give particulars.							
Total amount (\$)							
11. If there are any peculiar circumstances or condition about this case, please state them.							
Employer's signature				Title		Date <i>(yyyy-mm-dd)</i>	



**EMPLOYER'S STATEMENT
OF RETURN TO WORK**
(continued)

Worker last name	First name	Middle initial	WorkSafeBC claim number
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Additional information

For additional information on WorkSafeBC, please refer to our web site at WorkSafeBC.com.