WORKSAFE BC
WORKING TO MAKE A DIFFERENCE

INDEPENDENT OPERATOR'S APPLICATION FOR COMPENSATION AND REPORT OF INJURY OR OCCUPATIONAL DISEASE

As an employer, 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**.

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 *(if known)*

Contact information

Employer's name *(as registered with WorkSafeBC)*			
Type of business	Do you have an account with WorkSafeBC (POP)? Yes ❒ No ❒	WorkSafeBC account number	
Classification unit number	Operating location number		
Last name	First name		Middle initial
Preferred first name	Weight	Height	Gender M ❒ F ❒
Address line 1	Address line 2		
City	Province/state	Country *(if not Canada)*	Postal code/zip
Employer phone number *(please include area code)*	Extension	Home phone number *(please include area code)*	
Employer contact fax *(please include area code)*	Employer payroll contact fax *(please include area code)*		
Date of birth *(yyyy-mm-dd)* - -	Personal health number *(from BC CareCard)*	Social insurance number	

1. Do you need an interpreter? Yes ❒ No ❒	2. Preferred language
3. Dominant hand Left ❒ Right ❒	4. Occupation

Incident information

5. Date and time of incident *(yyyy-mm-dd)* a.m. ❒ p.m. ❒ **OR**	6. Period of exposure resulting in occupational disease *(yyyy-mm-dd)* From To
7. Describe how the incident happened	8. Describe the injury in detail *(what part of the body was injured)*
	9. Side of body injured Left ❒ Right ❒ Both ❒ Not applicable ❒
10. Describe the work incident location *(address, city, province)* and where incident occurred *(e.g. shop floor, lunchroom, parking lot)*	
11. Did the injury(ies) or exposure result from a specific incident? Yes ❒ No ❒	

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Independent Operator's Application for Compensation and Report of Injury or Occupational Disease *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number *(if known)*

Social insurance number	Personal health number from BC CareCard

Incident information *(continued)*

12. 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)* ☐

13. Were there any witnesses? Yes ☐ No ☐

14. Did the incident occur in British Columbia? Yes ☐ No ☐

15. Were your actions at time of injury for your business? Yes ☐ No ☐

16. Did the incident occur on employer's premises or an authorized worksite? Yes ☐ No ☐

17. Did the incident occur during your normal shift? Yes ☐ No ☐

18. Were you performing your regular work duties at the time of the incident? Yes ☐ No ☐

19. Did you receive first aid? Yes ☐ No ☐ Date *(yyyy-mm-dd)*
If yes, please provide first aid attendant name *(if known)*

20. Did you go to hospital, clinic, or visit a physician or qualified practitioner? Yes ☐ No ☐ Date *(yyyy-mm-dd)*
If yes, please provide provider name *(if known)*
If yes, please provide provider address *(if known)*

21. Prior to this incident, did you have any recent pain or disability in the area of your injury? Yes ☐ No ☐

Wage information

22. Did you miss work beyond the date of injury or exposure? Yes ☐ No ☐

If NO WORK WAS MISSED and NO CHANGE to duties/pay, proceed to bottom of last page to sign, date, and submit this report. If WORK WAS MISSED or if duties/pay have been MODIFIED, please answer ALL questions on this form.

23. Provide the base salary amount for this employment position at the time of injury $ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

24. Do you receive other amounts of compensation in addition to **base salary**? Yes ☐ No ☐
Do you receive vacation pay on every cheque? Yes ☐ No ☐
If yes, vacation pay ______%

Please select check boxes for any of the following amounts you receive in addition to **base salary** AND provide the amount:
Tips and gratuities ☐ $ ______ Room and board ☐ $ ______
Shift differential ☐ $ ______ Other ☐ $ ______
Overtime ☐ $ ______

25. If you are disabled from work, will you continue to receive:
Base salary? Yes ☐ No ☐
Other amounts of compensation in addition to **base salary**? Yes ☐ No ☐
Will you continue to receive vacation pay on every cheque? Yes ☐ No ☐
If yes, vacation pay ______%

Please select check boxes for any of the following amounts you will continue to receive in addition to **base salary** AND provide the amount:
Tips and gratuities ☐ $ ______ Room and board ☐ $ ______
Shift differential ☐ $ ______ Other ☐ $ ______
Overtime ☐ $ ______

26. Provide your **gross** earnings for the past 3 months or 12 weeks prior to the date of injury or exposure
$ 3 months ☐ 12 weeks ☐

27. Do you work a fixed-shift rotation? Yes ☐ No ☐

28. If no, please explain

29. If yes, show your normal work week by entering the paid hours

Sun	Mon	Tue	Wed	Thu	Fri	Sat

30. Did you continue to work past day of injury? Yes ☐ No ☐

31. Last day worked *(yyyy-mm-dd)*

32. Number of hours you were scheduled to work on last day worked

33. Number of hours you worked on last day worked

34. Number of hours paid by your employer on last day worked

Independent Operator's Application for Compensation and Report of Injury or Occupational Disease *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number *(if known)*

Social insurance number	Personal health number from BC CareCard

Return-to-work information

35. Have you returned to work? Yes ❐ No ❐	36. If **YES**: Date you returned to work *(yyyy-mm-dd)* Since the return to work, has there been any change to your work duties or will there be any change to your hours of work, your work schedule, or your rate of pay? Yes ❐ No ❐
37. If **NO**: Does your employer have any **modified** or **transitional** duties available? Yes ❐ No ❐ Have the modified or transitional duties been offered to you? Yes ❐ No ❐	38. If yes, please describe modified or transitional duties

Signature and report date

PLEASE READ CAREFULLY:
I declare all the information I have given on this report is true and correct, and I elect to claim compensation for the above-mentioned injuries or disease. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation benefits without advising WorkSafeBC (the Workers' Compensation Board). I authorize WorkSafeBC and the Workers' Compensation Appeal Tribunal to view or obtain a copy of records pertaining to my examination, treatment, history, and employment from any source whatsoever, including records of physicians, qualified practitioners, medical insurers, hospitals, and any employer. I understand the information is collected, used, and disclosed under the authority of the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. I acknowledge that WorkSafeBC may obtain and disclose information from my claim to my employer for the purpose of appeal, or may disclose such information to others in accordance with the law, including the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

39. Worker signature	40. Date of report *(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.

The BC Legislature provides impartial advisers on all workers' compensation matters. The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. They have offices throughout the province and can be contacted at **www.labour.gov.bc.ca/wab/** or by telephone: Richmond 604 713-0360, toll-free 1 800 663-4261; Victoria 250 952-4393, toll-free 1 800 661-4066; Kelowna 250 717-2096, toll-fee 1 866 881-1188.

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.