



NATUROPATHIC PHYSICIAN – THIS REPORT NEEDS TO BE COMPLETED AND SUBMITTED ONLY WHEN:

1. The worker will be disabled beyond the day of injury, or
2. If the claim is for Hernia, Back Condition, Shoulder or Knee Strain or Sprain, Occupational Disease, or
3. If WorkSafeBC (the Workers' Compensation Board) has requested this report.

The Workers Compensation Act requires that every physician's or qualified practitioner's first report, containing all the information requested, shall be furnished to WorkSafeBC within 3 days after the date of first attendance to the worker.

Completed reports are to be submitted via FAX to WorkSafeBC at the number provided below

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

Worker information

					WorkSafeBC claim number		
Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/>		Worker last name			First name		Middle initial
Ms. <input type="checkbox"/> Miss <input type="checkbox"/>		Address line 1					Address line 2
City	Province/State	Country (if not Canada)	Postal code/Zip	Phone number (please include area code)			
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of injury (yyyy-mm-dd)			Location of plant or project where injury occurred			
Who rendered first treatment? (if known)			Date first treated (yyyy-mm-dd)				
Date of birth (yyyy-mm-dd)		Personal health number (BC CareCard)					
Are you the worker's regular practitioner? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, how long has the worker been your patient? Less than 6 months <input type="checkbox"/> More than 6 months <input type="checkbox"/>			Check this box if the injury resulted from a specific incident <input type="checkbox"/>		
Are there prior or other problems affecting injury, recovery, and disability? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain							

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			
Worker's occupation			Employer's type of business			

Details of injury and clinical findings

1. Date of service (yyyy/mm/dd)					
2. What happened? (how the injury occurred)			3. Examination describe fully. (Please specify right or left)		
4. Diagnosis (text)					
5. Side of body Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable <input type="checkbox"/>					
6. Have X-rays been taken of this? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES, please send report to WorkSafeBC immediately.			7. Have X-rays been taken previously? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES, for what part of body and when? (yyyy-mm-dd)		
8. Treatment (including any operative procedure and date)				9. Frequency of treatment	





Worker last name			First name			Middle initial		
Date of birth (yyyy-mm-dd)			Personal health number (BC CareCard)			Social insurance number		

WorkSafeBC claim number

10. Date of next visit (yyyy-mm-dd)	11. Did the worker miss any time from work beyond the date of injury or exposure? Yes <input type="checkbox"/> No <input type="checkbox"/>	12. Last day worked (yyyy-mm-dd)
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13. Should the worker be referred for therapy, specialist consultation or diagnostic imaging? If yes, indicate type. If referred, date of referral (yyyy-mm-dd)

Rehabilitation program _____ Therapy _____
Specialist consultation _____ Diagnostic imaging _____

PLEASE NOTE
If, during treatment or convalescence, a worker wishes to leave BC, either temporarily or permanently, the worker must receive permission from both WorkSafeBC and the attending Naturopathic Physician. **Failure to do so may result in suspension of compensation benefits.**
If you become aware of a worker's intention to leave the province, please advise the worker of the above requirements and notify the appropriate WorkSafeBC office.

Return-to-work planning

1. Has the worker returned to work Yes <input type="checkbox"/> No <input type="checkbox"/>	2. If YES: Date (yyyy-mm-dd)
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3. If NO:

a) What are the current physical and/or psychological restrictions?

b) Estimated days before the worker will be able to return to **transitional** or **modified** duties
Currently at work 1-6 days 7-13 days 14-20 days 21-27 days > 28 days

c) Estimated days before the worker will be able to return to full shifts
Currently at work 1-6 days 7-13 days 14-20 days 21-27 days > 28 days

d) Estimated date of full maximal medical recovery (full recovery or best possible recovery yyyy/mm/dd)

4. Are there any modified or transitional duties available? Yes <input type="checkbox"/> No <input type="checkbox"/>	5. Have the modified or transitional duties been offered to the worker? Yes <input type="checkbox"/> No <input type="checkbox"/>
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6. If yes, please describe the modified or transitional duties.	7. Would you like a WorkSafeBC physician or nurse advisor to contact you regarding this patient? Yes <input type="checkbox"/> No <input type="checkbox"/> Comments
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Payee name	Payee number	Practitioner name	Practitioner number
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Stamp or type name and address of naturopathic physician or group and personally sign.	Address line 1	City	Postal code/zip
	Address line 2	Province/State	
	Phone number (please include area code)	Country (if not Canada)	
	Signature of naturopathic physician	Date (yyyy-mm-dd)	

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.