



QR code is for internal use

# Application for Compensation and Report of Injury or Occupational Disease



For your convenience, WorkSafeBC offers three options for reporting a work-related injury and filing a claim:

1. **Call our Teleclaim Centre** — The fastest and easiest way to report an injury and file a TIME-LOSS CLAIM is to call us at **1.888.WORKERS** (1.888.967.5377). One of our knowledgeable representatives will take your information over the phone, explain the process, and refer you to services to aid with your recovery and return to work. Teleclaim is available Monday to Friday, from 8 a.m. to 6 p.m.
2. **Report your injury online** — Go to **worksafebc.com** and select "Report a workplace injury" to input your information. You can submit your report online and, once submitted, you can follow the status of your claim online.
3. **Submit the paper form** — Clearly **PRINT** your information on the form below, sign it, and submit it by fax or mail.  
**FAX:** 604.233.9777 in Greater Vancouver, or toll-free within BC at 1.888.922.8807  
**MAIL:** WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

**For assistance**, please call:

- A. Claims Call Centre at 604.231.8888 or toll-free throughout Canada at 1.888.967.5377, Monday–Friday, 8 a.m. to 6 p.m.
- B. 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 who dispute WorkSafeBC decisions.  
 Phone: 604.335.5931  
 Toll-free: 1.800.663.4261  
 Website: [gov.bc.ca/workersadvisers](http://gov.bc.ca/workersadvisers)

## Information about you

Worker's last name		First name		Middle initial	
Preferred first name				Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Date of birth (yyyy-mm-dd)		Personal health number (BC Services Card/CareCard)		Social insurance number	
Address line 1		Address line 2			
City		Province/state		Country (if not Canada)	
Home phone number (please include area code)		Business phone number (please include area code)		Business extension	
Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred language		What is your dominant hand? <input type="checkbox"/> Left <input type="checkbox"/> Right	
				Height	
				Weight	

## Information about your employer

Employer's organization name			
Type of business (if known)		Operating location (if known)	
Address line 1		Address line 2	
City		Province/state	
Country (if not Canada)		Postal or ZIP code	
Employer's contact last name		First name	
Employer's phone number (please include area code)		Extension	

## Information about your employment

1. What is your occupation?	2. Have you been employed by this firm for less than 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. If yes, start date (yyyy-mm-dd)
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Worker's last name	First name	Middle initial	WorkSafeBC claim number
Social insurance number		Personal health number (BC Services Card/CareCard)	

4. At the time of injury, were you (please check all that apply)

<input type="checkbox"/> Permanent	<input type="checkbox"/> Apprentice	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Casual
<input type="checkbox"/> Temporary	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Principal/partner or relative of employer	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Full time	<input type="checkbox"/> Student	<input type="checkbox"/> Fisher	
<input type="checkbox"/> Part time	<input type="checkbox"/> New entrant to workforce	<input type="checkbox"/> Hired on a contract basis	

5. How many employers do you have?

## Incident information

6. Date and time of incident (yyyy-mm-dd) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <b>OR</b>	7. Period of exposure resulting in occupational disease (yyyy-mm-dd) From To	
8. Have you reported the injury/exposure to your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. The injury or disease was first reported to employer on (yyyy-mm-dd)	(please check one) TO: <input type="checkbox"/> First aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Other (please specify)
10. Name of person reported to		
11. If no, provide reason for not reporting to your employer		
12. Describe how the incident happened	13. Describe the injury in detail (what part of the body was injured)	
	14. Side of body injured <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable	
15. Describe the work incident location (address, city, province) and where incident occurred (e.g. shop floor, lunchroom, parking lot)		
16. Did your injury(ies) or exposure result from a specific incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
17. Contributing factors — select AT LEAST ONE, and as many as applicable		
<input type="checkbox"/> Lifting _____ <input type="checkbox"/> lb <input type="checkbox"/> kg	<input type="checkbox"/> Struck	<input type="checkbox"/> Animal bite
<input type="checkbox"/> Overexertion	<input type="checkbox"/> Crush	<input type="checkbox"/> Assault
<input type="checkbox"/> Repetitive (activity repeated over and over again)	<input type="checkbox"/> Sharp edge	<input type="checkbox"/> Motor vehicle accident
<input type="checkbox"/> Slip or trip	<input type="checkbox"/> Fire or explosion	<input type="checkbox"/> Unsure/other (please explain below)
<input type="checkbox"/> Twist	<input type="checkbox"/> Harmful substance in the work environment	_____
<input type="checkbox"/> Fall		_____
18. Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No	19. Did the incident occur in British Columbia? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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20. Were your actions at time of injury for your employer's business? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Did the incident occur on employer's premises or an authorized worksite? <input type="checkbox"/> Yes <input type="checkbox"/> No
22. Did the incident occur during your normal shift? <input type="checkbox"/> Yes <input type="checkbox"/> No	23. Were you performing your regular work duties at the time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
24. Did you receive first aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Date (yyyy-mm-dd)	If yes, please provide first aid attendant name (if known)
25. Did you go to hospital, clinic, or visit a physician or qualified practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No Date (yyyy-mm-dd)	If yes, please provide provider name (if known)
If yes, please provide provider address (if known)	
26. Prior to this incident, did you have any recent pain or disability in the area of your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Wage information

27. Did you miss work beyond the date of injury or exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No	If <b>no work was missed</b> and <b>no change</b> to duties/pay, proceed to bottom of page to sign, date, and submit this report. If <b>work was missed</b> or if duties/pay have been <b>Modified</b> , please answer <b>all</b> questions on this form.														
28. What is your current base salary amount for this employment position at the time of injury \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly															
29. Please provide total gross amount of earnings you receive from other employers \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly															
30. Do you receive other amounts of compensation in addition to <b>base salary</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you receive vacation pay on every cheque? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, vacation pay _____ % Please select check boxes for any of the following amounts you receive in addition to <b>base salary</b> AND provide the amount: <input type="checkbox"/> Tips and gratuities \$ _____ <input type="checkbox"/> Room and board \$ _____ <input type="checkbox"/> Shift differential \$ _____ <input type="checkbox"/> Other \$ _____ <input type="checkbox"/> Overtime \$ _____	31. If you are disabled from work, will you continue to receive: <b>Base salary</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No Other amounts of compensation in addition to <b>base salary</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No Will you continue to receive vacation pay on every cheque? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, vacation pay _____ % Please select check boxes for any of the following amounts you will continue to receive in addition to <b>base salary</b> AND provide the amount: <input type="checkbox"/> Tips and gratuities \$ _____ <input type="checkbox"/> Room and board \$ _____ <input type="checkbox"/> Shift differential \$ _____ <input type="checkbox"/> Other \$ _____ <input type="checkbox"/> Overtime \$ _____														
32. Provide your gross earnings for the past 3 months or 12 weeks prior to the date of injury or exposure \$ _____ <input type="checkbox"/> 3 months <input type="checkbox"/> 12 weeks															
33. Do you work a fixed-shift rotation? <input type="checkbox"/> Yes <input type="checkbox"/> No	34. If no, please explain														
35. If yes, show your normal work week by entering the paid hours	<table border="1"> <tr> <th>Sun</th> <th>Mon</th> <th>Tue</th> <th>Wed</th> <th>Thu</th> <th>Fri</th> <th>Sat</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	Sun	Mon	Tue	Wed	Thu	Fri	Sat							
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36. Did you continue to work past day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	37. Last day worked (yyyy-mm-dd)		
38. Number of hours you were scheduled to work on last day worked	39. Number of hours you worked on last day worked	40. Number of hours paid by your employer on last day worked	

## Return-to-work information

41. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	42. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
43. If NO: Does your employer have any modified or transitional duties available? <input type="checkbox"/> Yes <input type="checkbox"/> No Have the modified or transitional duties been offered to you? <input type="checkbox"/> Yes <input type="checkbox"/> No	44. If yes, please describe

### 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*.

45. Worker's signature	46. Date of report (yyyy-mm-dd)
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WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's FIPP Office at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, email [FIPP@worksafebc.com](mailto:FIPP@worksafebc.com), or call 604.279.8171.