WORK SAFE BC

Employer's 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. Please report using one of the following options:

1. **Online — The quickest and easiest option**: The online screen application customizes questions to the worker's injury. You can save your report and update it later with new information. Once submitted, you can follow the status of the claim online. Go to **worksafebc.com** and select "Report injury or illness."
2. **Fillable PDF form**: Type in your details online, print the form, and submit it by **fax** or **mail**. Go to **worksafebc.com** and select "Report injury or illness."
3. **Paper form**: Clearly **print** details, sign the form, 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

RESET

Employer information

WorkSafeBC claim number (if known)				
Employer's name (as registered with WorkSafeBC)				Type of business
WorkSafeBC account number		Classification unit number		Operating location number
Employer address line 1 (mailing)		Employer contact last name		First name
Employer address line 2 (mailing)		Employer contact telephone (and area code)	Extension	Employer contact fax (and area code)
City	Province/state	Employer payroll contact last name		First name
Country (if not Canada)	Postal code/zip	Employer payroll contact telephone (and area code)	Extension	Employer payroll contact fax (and area code)

Worker information

Worker last name	First name		Middle initial
Date of birth (yyyy-mm-dd) - -	Home phone number (include area code)		Social insurance number
Address line 1		Address line 2	
City	Province/state	Country (if not Canada)	Postal code/zip

1. What is the worker's occupation?	2. Has the worker been employed by this firm for less than 12 months? ☐ Yes ☐ No	3. If yes, start date (yyyy-mm-dd)

4. At the time of injury, was the worker (check all that apply)

☐ Permanent	☐ Apprentice	☐ Self-employed	☐ Casual
☐ Temporary	☐ Volunteer	☐ Principal/partner or relative of employer	☐ Other (specify)
☐ Full time	☐ Student	☐ Fisher	
☐ Part time	☐ New entrant to workforce	☐ Hired on a contract basis	

Incident information

5. Date of incident (yyyy-mm-dd) - -	Time of incident (hh:mm) ☐ am ☐ pm **OR**	6. Period of exposure resulting in occupational disease (yyyy-mm-dd) From To
7. Did worker report injury or exposure to employer? ☐ Yes ☐ No ▶	8. The injury or disease was first reported to employer on (yyyy-mm-dd)	(please check one) To: ☐ First aid ☐ Supervisor ☐ Office ☐ Other (specify)
9. Name of person reported to		

10. Describe how the incident happened	11. Describe the injury in detail (what part of the body was injured)
	12. Side of body injured ☐ Left ☐ Right ☐ Both ☐ Not applicable

13. Describe the work incident location (address, city, province) and where incident occurred (e.g. shop floor, lunchroom, parking lot)

14. Did the injury(ies) or exposure result from a specific incident?
☐ Yes ☐ No

WORK SAFE BC

Employer's Report of Injury or Occupational Disease

If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

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

Social insurance number	Personal health number (CareCard)	Date of incident (yyyy-mm-dd)	Date of birth (yyyy-mm-dd)
		- -	- -

15. 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 substances in the work environment
- ☐ Animal bite
- ☐ Assault
- ☐ Motor vehicle accident
- ☐ Unsure/other (please explain below)

16. Were there any witnesses? ☐ Yes ☐ No	17. Did the incident occur in British Columbia? ☐ Yes ☐ No
18. Were the worker's actions at time of injury for the purpose of your business? ☐ Yes ☐ No	19. Did the incident occur on employer's premises or an authorized worksite? ☐ Yes ☐ No
20. Did the incident happen during the worker's normal shift? ☐ Yes ☐ No	21. Was the worker performing their regular duties at the time of the incident? ☐ Yes ☐ No
22. Did the worker receive first aid? ☐ Yes ☐ No Date (yyyy-mm-dd) ▶	If yes, please provide first aid attendant name (if known)
23. Did the worker 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)	
24. Are you aware of any recent pain or disability in the area of the worker's reported injury? ☐ Yes ☐ No	
25. Do you have any objections to the claim being allowed? ☐ Yes ☐ No ▶	If yes, please explain

Wage information

26. Did the worker miss any time from 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 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.

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

28. Does worker receive other amounts of compensation in addition to **base salary**? ☐ Yes ☐ No
Does worker receive vacation pay on every cheque? ☐ Yes ☐ No
If yes, vacation pay _____%

Please select check boxes for any of the following amounts worker receives in addition to **base salary** AND provide the amount for each:
- ☐ Tips and gratuities $_____
- ☐ Room and board $_____
- ☐ Shift differential $_____
- ☐ Other $_____
- ☐ Overtime $_____

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

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

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

31. Does the worker have a fixed-shift rotation? ☐ Yes ☐ No

32. If no, please explain

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

Sun	Mon	Tues	Wed	Thu	Fri	Sat

34. Did the worker continue to work past day of injury? ☐ Yes ☐ No	35. Last day worked (yyyy-mm-dd)	
36. Number of hours scheduled to work on last day worked	37. Number of hours worked on last day	38. Number of hours paid by employer on last day worked

WORK SAFE BC

Employer's Report of Injury or Occupational Disease

If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

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

Social insurance number	Personal health number (CareCard)	Date of incident (yyyy-mm-dd)	Date of birth (yyyy-mm-dd)
		- -	- -

Return-to-work information

39. Has the worker returned to work?
☐ Yes ☐ No

40. If **Yes**: Date (yyyy-mm-dd)

Since the return to work, have the worker's duties, hours of work, work schedule, and/or rate of pay changed? ☐ Yes ☐ No

41. If **No**: Do you have any modified or transitional duties available?	42. If yes, please describe modified or transitional duties
☐ Yes ☐ No Have the modified or transitional duties been offered to the worker? ▶ ☐ Yes ☐ No	

Signature and report date

43. Employer signature	44. Employer title	45. Date of report (yyyy-mm-dd)

For assistance, please call our Claims Call Centre at 604.231.8888 or toll-free within Canada at 1.888.967.5377, M–F, 8:00 a.m. to 6:00 p.m.

Please note: If you have concerns with this claim, please contact the officer handling the claim at the WorkSafeBC office to make known your objections or you may submit a letter detailing your specific concerns. **Impartial advice on WorkSafeBC claims** — To ensure you have an opportunity to obtain impartial advice on WorkSafeBC claims matters, the BC legislature has provided impartial advisers. **Employers' Advisers** are available to provide independent advice or clarification on a WorkSafeBC claim related to your firm. For additional information on the Employers' Advisers, please refer to their website at **www.labour.gov.bc.ca/eao** or email: **eao@eao-bc.org**

Toll-free within Canada:
1.800.925.2233

Employers' Adviser Office locations:
Richmond, Langley, Kamloops, Kelowna, Nanaimo, Trail, Prince George, Victoria.

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, or email FIPP@worksafebc.com, or call 604.279.8171.