WORK SAFE BC

Dentist's Report of Injury

This report must be completed in detail and forwarded after the first examination to WorkSafeBC.

Indicate your **WORKSAFEBC PAYEE NUMBER** *in the space allotted at the bottom of this form. To obtain your payee number, please call:* 604 276-3344 or toll-free 1 888 422-2228, ext. 3344

Mail PO Box 4700 Stn Terminal Vancouver BC V6B 1J1
Fax 604 233-9777 or toll-free within BC 1 888 922-8807
WorkSafeBC Call Centre 604 231-8888 or toll-free within BC 1 888 967-5377

Worker information

WorkSafeBC claim number			
Title ❒ *Mr.* ❒ *Mrs.* ❒ *Dr.* ❒ *Ms.* ❒ *Miss*	Worker last name	First name	Middle initial
Address line 1		Address line 2	
City	Province/State	Country *(if not Canada)*	Postal code/Zip	Phone number *(include area code)*
Date of birth *(yyyy-mm-dd)* - -	Personal health number *(BC CareCard)*	Social insurance number	

Employer information

Employer name *(as registered with WorkSafeBC)*		Employer phone number *(include area code)*	
Address line 1	Address line 2		
City	Province/State	Country *(if not Canada)*	Postal code/Zip

Details of injury

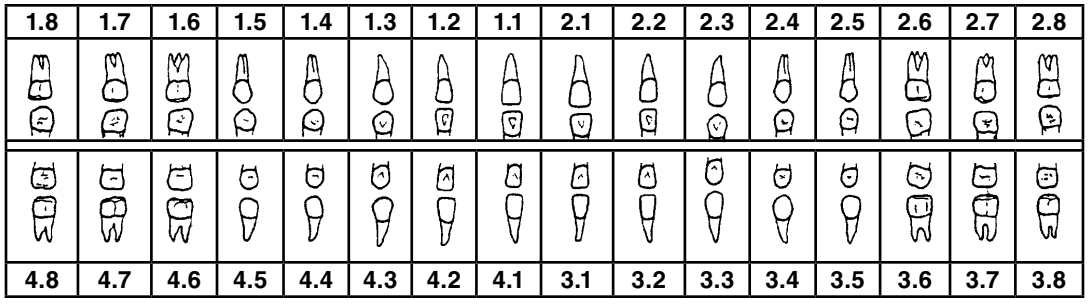
Employer's type of business	Date of injury *(yyyy-mm-dd)*	Location of plant or project where injury occurred

1. State condition of teeth or soft tissue **unrelated** to this injury *(e.g., perio disease, gingival recession, etc.)* *(pre-existing condition)*

2. Date first treated for injury *(yyyy-mm-dd)*

3. **ALL** OF THE FOLLOWING ITEMS **MUST** BE COMPLETED.

- Mark teeth injured "A".
- Mark the teeth to be extracted "✗".
- Draw a line through the teeth missing prior to the injury.



4. Side of body injured
❒ L ❒ R ❒ Bilateral
❒ Not applicable

5. Describe the extent of hard and soft tissue damage caused by this injury *(diagnosis)*.

6. Were any temporary procedures related to the injury carried out? If so, state teeth and code numbers.

7. ❒ Check this box if the injury resulted from a specific incident

Itemize treatment needed on a STANDARD DENTAL CLAIM FORM using British Columbia Dental Association (BCDA) fee guide CODES. Clearly indicate on the STANDARD DENTAL CLAIM FORM whether your request is "FOR PRE-AUTHORIZATION" or "FOR PAYMENT."

(Stamp or type name, address, and postal code of treating dentist and personally sign.)	Phone number *(include area code)*	**WorkSafeBC payee number**
	Fax number *(include area code)*	Date of service (date of examination) *(yyyy-mm-dd)*
	Signature of dentist	Date of report *(yyyy-mm-dd)*

WORK SAFE BC

Dentist's Report of Injury
(continued)

WorkSafeBC claim number			
Title ❒ Mr. ❒ Mrs. ❒ Dr. ❒ Ms. ❒ Miss	Worker last name	First name	Middle initial
Date of birth *(yyyy-mm-dd)* - -	Personal health number *(BC CareCard)*	Social insurance number	

Additional information

Visit our website at **WorkSafeBC.com**
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Other assistance
The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. The Workers' Advisers have offices throughout the province and can be contacted at www.labour.gov.bc.ca/wab/

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.