YUKON WORKERS' COMPENSATION HEALTH AND SAFETY BOARD

EMPLOYER'S REPORT OF INJURY/ILLNESS

ÉGALEMENT DISPONIBLE EN FRANÇAIS

Claim number:

Workers' Compensation, Health and Safety Board (WCHSB)
401 Strickland Street, Whitehorse, Yukon, Canada • Y1A 5N8
fax (867) 393-6279, phone (867) 667-5645
toll free 1-800-661-0443 (valid in the Yukon, B.C., Alberta, Saskatchewan)

This information is being collected under the authority of the Workers' Compensation Act for the purpose of determining eligibility for benefits. For further information contact/direct inquiries to the Director, Claimant Services Branch at (867) 667-8032.

Renseignements obtenus en vertu de la *Loi sur accidents du travail* pour déterminer l'admissibilité aux indemnités. Pour en savoir davantage, s'adresser au directeur/à la directrice des services aux prestataires au (867) 667-8032.

Please answer all questions, sign and return to the Board within 3 days of notification of every injury/illness.

WORKER INFORMATION

1. Worker's name _____ (last name / first name / initial)
2. Mailing address _____
3. Postal code _____ 4. Telephone number (____) _____ (area code)
5. Worker's occupation _____
6. Social insurance number _____
7. Health insurance number _____ _____ (territory or province)

EMPLOYER INFORMATION

8. Employer and/or legal company name (include government department if applicable) _____
9. Mailing address _____
10. Postal code _____ 11. Telephone number (____) _____ (area code)
12. Name of supervisor _____
13. WCHSB account number _____

INJURY/ILLNESS INFORMATION

14. Date, time and place where the injury/illness occurred.
_____ (year/month/day) (am/pm) (city, town or place)
15. What part of the worker's body was injured? (Also, please indicate left or right.) _____
16. What type of equipment was being used? _____
17. What happened to cause the injury/illness? (Please use a separate sheet if necessary.) _____
18. Was first aid given at the work site? ☐ yes ☐ no
19. If yes, state name and title of the person who gave first aid. _____

ADDITIONAL INFORMATION

20. When was the worker first absent from work as a result of this injury/illness?
_____ (year/month/day)
21. Will you pay the worker regular wages while the worker is off work due to this injury? ☐ yes ☐ no
22. Has the worker returned to work? ☐ yes ☐ no
23. If yes, on what date? _____ (year/month/day)
24. Will the worker's job be available when the worker is fit to return to work? ☐ yes ☐ no ☐ uncertain
25. Were the worker's actions at the time of injury/illness for the purpose of your business? ☐ yes ☐ no
26. Were the actions part of the worker's regular work? ☐ yes ☐ no
27. Did the actions happen on your premises? ☐ yes ☐ no
28. Are you satisfied the injury/illness occurred as reported by the worker and/or witnesses? ☐ yes ☐ no If no, give details. _____
29. Was a motor vehicle involved in this injury? ☐ yes ☐ no
30. Was another employer or their worker involved in this injury? ☐ yes ☐ no
31. If yes, give the name of the worker or employer and the company involved. _____
32. Is the worker the proprietor or partner or director of the incorporated company? ☐ yes ☐ no
33. If yes, specify _____
34. Does the worker hire her/his own help? ☐ yes ☐ no

EARNINGS INFORMATION

35. When did the worker begin working for your company? _____ (year/month/day)
36. How many hours per week does the worker work for you? _____ (hours/week)
37. Check any of the following which may apply to your worker.
☐ permanent work ☐ seasonal/casual ☐ piece worker
☐ owner/proprietor ☐ sub-contractor ☐ employer
38. What was the worker's rate of pay at the time of the injury/illness? $ ____ per ____
39. Does the worker receive room and board in addition to wages? ☐ yes ☐ no
40. If yes, what is the taxable value of the room and board? $ _____
41. What other earnings/benefits, such as commissions, overtime, bonuses, tips or allowances, do you provide to your worker? Please give the estimated dollar value of these benefits/earnings.

Additional earnings/benefits	$value
_____	$ _____ per _____
_____	$ _____ per _____
_____	$ _____ per _____

42. Please give the worker's gross earnings, including additional earnings/benefits received in your employ during the past 12 months. $ _____

I declare that the above information is true and correct and I am authorized to sign this report on behalf of the employer.

Signature _____ Title _____ Date _____

Please note, failure to report an injury/illness within 3 days of notification may result in a fine.