YUKON WORKERS' COMPENSATION HEALTH AND SAFETY BOARD

WORKER'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.

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. Time in your present occupation? _____ (years/months)
7. Date of birth _____ 8. Social insurance number _____
9. Health insurance number _____ _____ (territory or province)

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

INJURY/ILLNESS INFORMATION

15. Date, time and place where the injury/illness occurred. _____ (year/month/day / am/pm / city, town or place)
16. What were your hours of work on the day of the injury/illness? _____ (from / to)
17. What part of the worker's body was injured? (Also, please indicate left or right.) _____
18. What type of equipment was being used? _____
19. What happened to cause the injury/illness? (Please use a separate sheet if necessary.) _____
20. List any witnesses, if applicable. _____
21. Name and title of who you reported the injury/illness to? _____
22. Date and time you reported the injury/illness? _____
23. Was first aid given at the work site? ☐ yes ☐ no
    If yes, give name and title of the person who gave first aid. _____
24. Did you have to go to a hospital? ☐ yes ☐ no
    If yes, give name and address of hospital. _____
25. Did you see a doctor? ☐ yes ☐ no
    If yes, give name and address of doctor. _____

ADDITIONAL INFORMATION

26. When were you first absent from work as a result of this injury/illness? _____ (year/month/day)
27. Were you performing work for your employer when the injury occurred? ☐ yes ☐ no
28. Did the injury/illness happen on the employer's premises? ☐ yes ☐ no
29. Was a motor vehicle involved in this injury? ☐ yes ☐ no
30. Was another employer or their worker involved in this injury/illness? ☐ yes ☐ no
31. If yes, give the name of the worker or employer and the company involved. _____
32. Have you returned to work? ☐ yes ☐ no
33. If yes, when? _____ (year/month/day)
34. Have you had a similar injury before? ☐ yes ☐ no

EARNINGS INFORMATION

35. How many hours per week do you work for your present employer? _____ (hours/week)
36. Check any of the following which may apply to you and your earnings.
    ☐ permanent work ☐ seasonal/casual ☐ piece worker
    ☐ owner/proprietor ☐ sub-contractor ☐ employer
37. What was your rate of pay at the time of the injury/illness? $ _____ per _____
38. Do you receive room and board in addition to wages? ☐ yes ☐ no
39. If yes, what is the taxable value of the room and board? $ _____
40. What additional benefits/earnings, such as commissions, overtime, bonuses, tips or allowances, do you receive? Please list estimated dollar value of these benefits/earnings.

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

41. Do you have earnings from other sources, such as a second job? ☐ yes ☐ no
42. If yes, please list other sources and give your estimated earnings.
    _____ (employer's name/other source) $ _____ per _____
43. Please estimate your total earnings, including additional earnings/benefits; for the past 12 months. $ _____

You are required to provide written notification of this injury/illness to your employer. This may be done by giving your employer the middle copy of this completed form.

I declare that the above information is true and correct and I claim compensation accordingly.

_____ Signature _____ Title _____ Date