WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

WORKER'S REPORT OF ACCIDENT/APPLICATION FOR BENEFITS

If you are injured at work, you need to fill out this form. Your claim will not proceed until you send us this form.
Report this accident to your employer immediatly.

Worker Information

Last Name	First Name		Email Address
Street Address			
Mailing Address	Community	Postal Code	
Telephone (include area code)	Fax (include area code)	Date of Birth YY MM DD	❑ Male ❑ Female
Social Insurance Number	❑ Single ❑ Married ❑ Common-law ❑ Widowed ❑ Divorced	Number of Dependants	
Job Title	Preferred language ❑ English ❑ French ❑ Inuktitut If not, what language?		

Employer Information

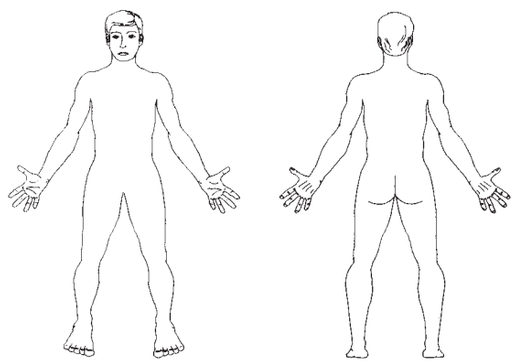
Employer Name	Address
Supervisor's Name	Telephone (include area code)

Accident Details

1. Date of accident YY MM DD Time AM / PM	2. Place where accident occurred
3. Date first disabled from work YY MM DD Time AM / PM	4. Did the accident occur on your employer's premises? ❑ Yes ❑ No If no, explain
5. Date reported to employer YY MM DD Time AM / PM	6. Name, position and telephone number of person to whom accident was reported:

IMPORTANT

7. Please describe the accident in as much detail as possible. (Use separate sheet if necessary)



8. **IMPORTANT – Please list any witnesses** Name and Address – include phone or contact number	Name and Address – include phone or contact number

9. Have you returned to work? ❑ Yes ❑ No If yes, ❑ Light Duties ❑ Regular Duties	When did you return?	YY MM DD	
10. Have you been offered light duties? ❑ Yes ❑ No			
11. Name of attendant if first aid was provided? Where?	When?	YY MM DD	
12. Name and address of attending health care professional.			
13. What Hospital / Health Centre did you go to?	When?	YY MM DD	

Past Injuries

14. Have you ever had an injury or disability to the same body part? (i.e. left foot, right hand)

15. Have you had previous claims with this Workers' Compensation Board, or any other Workers' Compensation Board? If yes, provide dates and nature of injury.

IF DISABLED LONGER THAN THE DATE OF THE ACCIDENT, PLEASE CONTINUE.
IF NOT, PLEASE SIGN AT THE BOTTOM OF THE NEXT PAGE.

Worker's Full Name:

Wage Information - If you are disabled longer than the date of accident please complete

16. Were you paid anything during your period of disability? ❑ Yes ❑ No

If yes, explain

17. Type of employment:
❑ permanent ❑ seasonal ❑ casual
❑ summer student ❑ apprentice ❑ part-time

18. Is the job subject to:
seasonal layoffs: ❑ Yes ❑ No
lack of work layoffs: ❑ Yes ❑ No

19. First day of hire: | YY | MM | DD |

20. Specify amount of time off for lunch. Are you paid for the time?

21. What is your hourly rate of pay?
$ ________ /hr

How often are you paid? ❑ Weekly ❑ Bi-Weekly ❑ Monthly
❑ Other – please explain

22. Do you receive any other benefits? ❑ Yes ❑ No If yes, explain and give amounts.
(i.e. vacation pay, settlement allowance, etc.)

23. Usual days and hours in work week: hours ________ days ________ from ___:_____ AM/PM to ___:_____ AM/PM

Circle days on:

M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T W T F S S

24. Do you regularly work overtime? ❑ Yes ❑ No
Provide an estimate of regular overtime hours (weekly / monthly / year)

25. Overtime Rate: $________ /hr

26. If you work an irregular work week (shifts, turnarounds, etc.), please supply one complete shift cycle:

Date shift cycle started ________ number of days on ________ number of days off ________

Circle days on:

M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T W T F S S

27. Do you have a second job?
❑ Yes ❑ No

If yes, have you missed time from this job due to your injury?
❑ Yes ❑ No

Name of employer: ________ Contact name and phone: ________

Please complete this section if you are a non-permanent employee

28. **For the 12 months prior to your date of accident who were your employers?**
(attach extra sheets if necessary)

Name of Company ________ from | YY | MM | DD | to | YY | MM | DD |

Total Earnings ________ Address / Phone Number ________

Name of Company ________ from | YY | MM | DD | to | YY | MM | DD |

Total Earnings ________ Address / Phone Number ________

PLEASE PROVIDE PROOF OF THESE EARNINGS (T4s, Paystubs, Record of Employment, etc.)

IF YOU FILED FOR ANY OTHER MONEY FROM OTHER SOURCES (EXAMPLE: SOCIAL ASSISTANCE, EMPLOYMENT INSURANCE, SHORT TERM DISABILITY, ETC.) IT IS YOUR RESPONSIBILITY TO INFORM OUR OFFICE WHILE RECEIVING WCB BENEFITS.

I declare all the information I have given on this form is true and correct and I elect to claim compensation for the above mentioned injuries or disease. This will authorize the board and boards of review to obtain or view, from any source whatsoever, including records of physicians, qualified practitioners or hospitals, a copy of records pertaining to examination, treatment, history and employment of the undersigned. **I understand it may be a criminal offence to knowingly make a false claim or to work and earn income while receiving workers' compensation without advising the board.** Failure to complete all sections may result in a delay of administration of my claim.

Print Name	Signature
Signed at (Community)	Date

Any personal information, as defined by the Access to Information and Protection of Privacy Act (ATIP), request herein is for the purpose of administering the *Workers' Compensation Act* and is authorized by the Act. For more information, please contact the WCB ATIP Coordinator at the appropriate number below.

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax 1-866-277-3677
or
❑ Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8501

Ce formulaire est disponible en français.
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