



EMPLOYER'S PROGRESSIVE INJURY QUESTIONNAIRE

P.O. BOX 2415,
EDMONTON, ALBERTA
T5J 2S5
Fax: (780) 427-5863
1-800-661-1993

		Claim Number	
Will worker be off work due to this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the worker on modified duties? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Worker's Name (Surname)		Personal Health Number	
(First Name)		(Year / Month / Day)	
(Initial)		Date of Birth	
Employer Name:		Employer Account Number:	

To help us decide if the workers' injury is work related, we require answers to the following questions:

What is the worker's job title? _____

Describe a typical work day.

How long has this been a typical work day? _____

Describe any changes to the work day which may have caused or increased the worker's symptom(s)? _____

When were the symptom(s) first reported? _____

Location of symptom(s). (Please check appropriate box(es))

	Right	Left		Right	Left		Right	Left
Hand	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Forearm	<input type="checkbox"/>	<input type="checkbox"/>
Fingers	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	Lower back	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____							

Worker's Name (Surname) (First Name) (Initial) Claim Number

Tasks worker perform in the job:

	Perform these tasks		Continuous?		How long does the worker perform the task each time?	How many times per day does the worker do the task?
	Yes	No	Yes	No		
Keyboarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mouse Usage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mail Sorting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cashiering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	If yes, mark with an "X". 0 lb 10 lb 20 lb 40 lb 60 lb 80 lb 100 lb Unlimited		_____	_____
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	If yes, mark with an "X". 0 lb 10 lb 20 lb 40 lb 60 lb 80 lb 100 lb Unlimited		_____	_____
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	If yes, mark with an "X". 0 lb 10 lb 20 lb 40 lb 60 lb 80 lb 100 lb Unlimited		_____	_____
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	If yes, mark with an "X". 0 lb 10 lb 20 lb 40 lb 60 lb 80 lb 100 lb Unlimited		_____	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

List tools/equipment used: _____

When are the scheduled breaks? _____

How long? _____ minutes How often? _____ minutes

List any hobbies, sporting, volunteer or recreational activities that you are aware of. _____

Do you have any other information about this injury? _____

Date: _____ Name (please print): _____ Signature: _____

Position: _____ Telephone Number _____

If we need to obtain further information when is the best time for us to reach you? _____

In order that this claim can be handled as quickly as possible, please return this information by either:

- Fax **(780) 427-5863 or 1-800-661-1993** If you fax the report, do not send another by mail.
- or
- Mail to: **WCB, PO Box 2415, Edmonton, AB T5J 2S5**

**Any questions? Edmonton: (780) 498-3800, Calgary: (403) 517-6000,
Toll Free: 310-0000 (ask operator for Edmonton 498-4000 or Calgary 517-6000)**