



Employer's Initial Report of Injury

WCB Claim No.:

Reporting Options: (1) WCB Telefile 1-800-787-9288 (2) WEB www.wcbsask.com (3) Fax

Section A: Employer Information

Name, address, postal code

Type of Business: Phone Number: Contact Person: E-mail: Fax Number: WCB Firm No.: Industry Rate Code:

Section B: Worker Information

Name, address, postal code

Specific Division (if applicable): Occupation: Social Insurance Number: Personal Health Number: Birthdate: Sex: Male Female Hire Date:

Section C: Injury Information

1. Injury date: 2. Reported to employer on: 3. Province of injury: 4. Area of body injured: 5. Name of healthcare provider: 6. How did the injury happen? 7. Has the employee lost time from work... 8. First day off and time employee left work... 9. Has employee returned to work... 10. Do you have any reason to believe that this is not a work-related incident?

Section D: Wage and Employment Information

11. How is the employee paid? 12. Provide gross earnings for the 12 months preceding first day off work... 13. Time lost during the gross earning period due to: 14. Normal working hours for employee: 15. Does the employee have regular days off? 16. TD1 Exemptions: 17. Should compensation payments be made to: 18. Will employee be paid for statutory holidays?

Section E: Declaration

I declare that all the information provided is true and correct to the best of my knowledge.

Date Name (please print) Title Signature