WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

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EMPLOYER'S STATEMENT OF RETURN TO WORK

This statement may be used to notify WorkSafeBC (the Workers' Compensation Board) of an injured worker's return to work.

Claim number

EMPLOYER'S NAME *(as registered with WorkSafeBC)*	Telephone number	**WORKER'S LAST NAME** *(please print)* ❒ *Mr.* ❒ *Ms.* ❒ *Mrs.* ❒ *Miss*	
Mailing address		First name(s)	Middle initial
City	Postal code	Mailing address	
Location of plant or project where injury occurred	Postal code	City	Postal code
Date of injury *Month Day Year*		Date of birth *Month Day Year*	Social insurance number
Worker's occupation		Worker's personal health number from BC CareCard	Telephone number

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1. Date worker was first laid off work — 20 , at o'clock ❒ a.m. ❒ p.m.

2. Has worker returned to work? ❒ YES ❒ NO From 20 , at o'clock ❒ a.m. ❒ p.m.

3. Did this employee work between first time off and final return or recovery? If so, please give dates.
❒ YES ❒ NO From 20 , at o'clock ❒ a.m. ❒ p.m.
To 20 , at o'clock ❒ a.m. ❒ p.m.

4. Did worker return to work as soon as possible? *(please give your opinion)*

OR

4A. If not returned to work, is the worker able to do so? *(please give your opinion)*

5. On what date do you consider the worker was first able to return to work? 20 , at o'clock ❒ a.m. ❒ p.m.

6. How many working days or shifts did the worker miss? ❒ Days ❒ Shifts

7. Is the worker earning or able to earn as much as before the injury? ❒ YES ❒ NO Now earning $ per week

8. If not, how much has the injury reduced the earnings? Now earning $ per week

9. How long is this impairment of earning capacity likely to continue?

10. Have you paid or allowed the worker anything for the period of disability? If so, please give particulars.

Total amount $

11. If there are any peculiar circumstances or condition about this case, please state them.

Employer's signature	Title	Date *Month Day Year*

☛ **ADDITIONAL INFORMATION CAN BE RECORDED ON PAGE 2 OF THIS STATEMENT.**
Please see page 2 for telephone and fax numbers.

WORKERS' COMPENSATION BOARD OF B.C.

Worker's last name	First name	Middle initial	Social insurance number	WorkSafeBC claim number

Worker's personal health number from BC CareCard									

Additional information

Mailing address for report and all claims correspondence: WorkSafeBC
PO Box 8940 Stn Terminal
Vancouver BC V6B 1H9

Fax number: Local 604 233-9722 or toll free within BC 1 888 922-8803.

For additional information on WorkSafeBC, please refer to our web site at **WorkSafeBC.com**.

Telephone information

Call Centre: 604 231-8888 or toll free within BC 1 888 967-5377.

Occupational Disease Services: 604 276-3007 or toll free within BC 1 888 967-5377(extension 3007).

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.

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