WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

DENTIST'S REPORT

This report must be completed in detail and forwarded after the first examination to the WCB.

By fax: 604 276-3195 or toll free within BC 1 888 922-3299 **Or by mail:** PO Box 94460 Stn Main Richmond BC V6Y 2V6

Please indicate your WCB **VENDOR NUMBER** in the space allotted at the bottom of this form.

WCB claim number

EMPLOYER'S NAME *(as registered with the Board)*		**WORKER'S LAST NAME** *(please print)* Mr., Ms. Mrs., Miss	
Mailing address		First name(s)	Middle initial
City	Postal code	Mailing address	
Date of injury MONTH DAY YEAR	Telephone number	City	Postal code
Location of plant or project where injury occurred		Date of birth MONTH DAY YEAR	Social insurance number
Employer's type of business		Worker's personal health number from BC CareCard	Telephone number

3
8
2

1. Please state condition of teeth or soft tissue **unrelated** to this injury (e.g. perio disease, gingival recession, etc.)

2. **ALL OF THE FOLLOWING ITEMS MUST BE COMPLETED.**
   - Mark teeth injured "A".
   - Draw a line through the teeth missing prior to the injury.
   - Mark the teeth to be extracted "✗".

1.8	1.7	1.6	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8
4.8	4.7	4.6	4.5	4.4	4.3	4.2	4.1	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8

3. Please describe the extent of hard and soft tissue damage caused by this injury.

4. Were any temporary procedures **related to the injury** carried out? If so, please state teeth and code numbers.

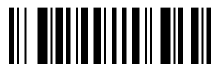
PLEASE ITEMIZE TREATMENT NEEDED ON A "STANDARD DENTAL CLAIM FORM" USING BRITISH COLUMBIA DENTAL ASSOCIATION (BCDA) FEE GUIDE CODES. Please clearly indicate on the "STANDARD DENTAL CLAIM FORM" whether your request is "FOR PRE-AUTHORIZATION" or "FOR PAYMENT".

(Stamp or type name, address, and postal code of treating dentist and personally sign.)	Telephone number	**WCB vendor number**
	Fax number	Date of examination
	Signature of dentist	Date

ADDITIONAL INFORMATION CAN BE RECORDED ON PAGE 2 OF THIS FORM.

☛ **Please see page 2 of this report for phone and fax numbers.**

WORKERS' COMPENSATION BOARD OF B.C.



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

Worker's personal health number from BC CareCard									

Additional information

Personal information on this form is collected for the purposes of administering a worker's compensation claim by the Board in accordance with the ***Workers Compensation Act*** and the ***Freedom of Information and Protection of Privacy Act***. For further information, please contact the Board's Freedom of Information Coordinator at 6951 Westminster Highway, Richmond, BC, V7C 1C6, or telephone 604 279-8171.

Visit our web site at **www.worksafebc.com**

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Richmond BC V6Y 2V6

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Telephone information

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

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

Other assistance

The Workers' Advisers Office is independent and separate from the WCB and provides free advice and assistance to help injured workers with their claims. The Workers' Advisers have offices throughout the province and can be contacted at **www.labour.gov.bc.ca/wab/** or by telephone at:

Richmond	604 713-0360	or toll free	1 800 663-4261
Victoria	250 952-4393	or toll free	1 800 661-4066
Kelowna	250 717-2096	or toll free	1 866 881-1188