

**SELECT ONE ONLY:**     **Chiropractor's First Report (F8C)**     **Chiropractic treatment expected to go beyond four weeks (F11C)**  
*(Submit following the worker's first visit to your office/facility.)*                      *(Submit **prior** to the end of the fourth week of chiropractic treatment **ONLY** if treatment is to go beyond four weeks, **or** if there is a change in the worker's condition since the last report, **or** if the worker is ready for return to work.)*

Date of service (yyyy/mm/dd) / /		Date of birth (yyyy/mm/dd) / /		WorkSafeBC (WCB) claim number	
Employer's name		Worker's last name			
Employer's telephone number <i>(must include area code)</i> ( )		First name		Middle initial	Gender
Operating location address		Mailing address <i>(include postal code)</i>			
Date of injury or when patient was first treated for this condition (yyyy/mm/dd) / /		Worker's contact telephone number <i>(must include area code)</i> ( )			
Who rendered first treatment?		Worker's personal health number from B.C. CareCard			
Are you the worker's regular practitioner? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If YES, how long has the worker been your patient? <input type="checkbox"/> 0-6 months <input type="checkbox"/> 7-12 months <input type="checkbox"/> > 1 year					
Are there prior or other problems affecting injury, recovery, and disability?					
From injury or last report, has the worker been disabled from work? <input type="checkbox"/> YES <input type="checkbox"/> NO    If YES, as of what date? (yyyy/mm/dd)					
Is the worker receiving other concurrent treatments? <input type="checkbox"/> YES <input type="checkbox"/> NO    If YES, select <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Massage therapy <input type="checkbox"/> Other					

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**Injury Codes and Descriptions**

Diagnosis <i>(text)</i>		
CSA BP/AP <i>(code)</i>	CSA NOI <i>(code)</i>	ICD9 <i>(code)</i>

**Clinical Information**

What happened? Subjective Sx, examination, X-rays used in investigations, treatment types (i.e. "techniques" and modalities) being used and frequency, specialists consult?

**Return-to-work Planning**

Is the worker now medically capable of working full duties, full time?     YES     NO  
If NO, what are the current physical and/or psychological restrictions?

Estimated time before the worker will be able to return to the workplace in any capacity  
 Currently at work     1-6 days     7-13 days     14-20 days     > 20 days

If appropriate, is the worker now ready for a rehabilitation program?     YES     NO    If YES, select     WCP    or     Other

Do you wish to consult with a WorkSafeBC physician, psychologist, chiropractic consultant, or nurse advisor?     YES     NO

If possible, please estimate date of maximal medical recovery *(full recovery or best possible recovery yyyy/mm/dd)*

Payee number	Practitioner number
Payee name	Practitioner name



The *Workers Compensation Act* requires that the *Chiropractor's First Report*, containing all the information requested, shall be furnished to WorkSafeBC within **3 days** after the date of first attendance to the worker.

**Practitioner — This report needs to be completed and submitted only when, in the case of a First Report (F8C), you suspect the worker may be disabled beyond the day of injury.**

**In the case of a follow-up visit, submit only (F11C):**

1. If the worker's condition or treatment has changed since the last report or if the worker is ready for Return to Work
2. It is not necessary to answer the following questions if completing a report for a follow-up visit (F11C)
  - Are you the worker's regular practitioner? If YES, how long has the worker been your patient?
  - Who rendered first treatment?

IN ALL OTHER CASES, ONLY YOUR PRACTITIONER ACCOUNT FOR PROCEDURES OR VISIT IS REQUIRED.

**Completed Practitioner Reports (paper versions) should be sent by facsimile (fax) to:**

Lower Mainland

Fax 604 276-3195

Toll Free

Fax 1 888 922-3299

**or by mail to:**

WorkSafeBC

PO Box 94460 Stn Main

Richmond BC V6Y 2V6

**For claim/claimant inquiries, contact:**

Call Centre

604 231-8888 or toll free 1 888 967-5377

**For invoice inquiries, contact Payment Services:**

Lower Mainland

604 276-3085

Toll Free

1 888 422-2228

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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<b>Chiropractor Office Use Only</b>
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