

NATUROPATHIC PHYSICIAN — THIS REPORT NEEDS TO BE COMPLETED AND SUBMITTED ONLY WHEN:

1. The worker will be disabled beyond the day of injury, or
2. If the claim is for Hernia, Back Condition, Shoulder or Knee Strain or Sprain, Occupational Disease, or
3. If WorkSafeBC (the Workers' Compensation Board) has requested this report.

IN ALL OTHER CASES, ONLY YOUR NATUROPATHIC PHYSICIAN'S FINAL REPORT AND ACCOUNT (Form 11AN) IS REQUIRED.

The *Workers Compensation Act* requires that every physician's or qualified practitioner'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.

		WorkSafeBC claim number	
EMPLOYER'S NAME (as registered with WorkSafeBC)		Telephone number	WORKER'S LAST NAME (please print) Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/>
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 and time of injury	20 at a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Date of birth	Social insurance number
When did you first treat?	20 at a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Month Day Year	Telephone number
Who rendered first treatment? (if known)		Worker's personal health number from BC CareCard	
When?	20 at a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Worker's occupation	
Date of next visit			
1. Cause of injury or disease (worker's statement)			
2. Are there any relevant pre-existing or associated conditions?			
3. Examination Describe fully. Please specify right or left.			
4. Diagnosis			
5. Have X-rays been taken of this? YES <input type="checkbox"/> NO <input type="checkbox"/> (If YES, please send report to WorkSafeBC immediately.)		6. Have X-rays been taken previously? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, for what part of body and when?	
7. Treatment (including any operative procedure and date)			
8. Frequency of treatment			
9. Name of specialist (if referred)		10. Date of referral	
11. Estimate period of work time loss Nil <input type="checkbox"/> 1-10 days <input type="checkbox"/> 11 or more days <input type="checkbox"/>			
12. Date worker was first disabled		13. Date worker fit to return to work	
14. Name of hospital		15. Date of admission	
PLEASE NOTE			
If, during treatment or convalescence, a worker wishes to leave BC, either temporarily or permanently, the worker must receive permission from BOTH WorkSafeBC and the attending Naturopathic Physician.			
Failure to do so may result in suspension of compensation benefits.			
If you become aware of a worker's intention to leave the province, please advise the worker of the above requirements and notify the appropriate WorkSafeBC office.			
Please stamp or type name and address of Naturopathic Physician or group and personally sign.		Mailing address	Postal code
		Payee number	Telephone number
		Signature of Naturopathic Physician	Date

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Worker's last name	First name	Middle initial	Social insurance number	WorkSafeBC (WCB) claim number
				Worker's personal health number from BC CareCard

Additional information

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

Lower Mainland
Toll-free

Fax 604 276-3195
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
Occupational Disease Services

604 231-8888 or toll-free 1 888 967-5377
604 276-3007 or toll-free 1 888 967-5377, ext. 3007

For invoice inquiries, contact Payment Services:

Lower Mainland
Toll-free

604 276-3085
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.