WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

RESET

EMPLOYER'S REPORT OF INJURY OR OCCUPATIONAL EXPOSURE

As an employer, the *Workers Compensation Act* requires you to submit this report **within three days** of an injury to one of your workers, even if you disagree with the claim. By submitting your report promptly, you avoid penalties and delays in the adjudication of the claim. Please report using one of the following options:

1. **Online — The quickest and easiest option**: The online screen application customizes questions to the worker's injury. You can save your report and update it later with new information. Once submitted, you can follow the status of the claim online. Go to **WorkSafeBC.com** and select "Report an injury or illness."
2. **Fillable PDF form**: Type in your details online, print the form, and submit it by **FAX** or **MAIL**. Go to **WorkSafeBC.com** and select "Report an injury or illness."
3. **Paper form**: Clearly PRINT details, sign the form, and submit it by **FAX** or **MAIL**.
   FAX: **604 233-9777** in Greater Vancouver or **toll-free** within BC at **1 888 922-8807**
   MAIL: WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

WorkSafeBC claim number *(if known)*

Employer information

Employer's name *(as registered with WorkSafeBC)*			Type of business
WorkSafeBC account number	Classification unit number		Operating location number
Employer address line 1 *(mailing)*	Employer contact last name		First name
Employer address line 2 *(mailing)*	Employer contact telephone *(and area code)*	Extension	Employer contact fax *(and area code)*
City / Province/state	Employer payroll contact last name		First name
Country *(if not Canada)*	Employer payroll contact telephone *(and area code)*	Extension	Employer payroll contact fax *(and area code)*

Worker information

Worker last name	First name	Middle initial	Gender M ❒ F ❒
Date of birth *(yyyy-mm-dd)* – –	Home phone number *(include area code)*	Social insurance number	
Address line 1	Address line 2		
City / Province/state	Country *(if not Canada)*	Postal code/zip	

1. What is the worker's occupation?

2. Has the worker been employed by this firm for less than 12 months? Yes ❒ No ❒

3. If yes, start date *(yyyy-mm-dd)*

4. At the time of injury, was the worker *(check all that apply)*

Permanent ❒	Apprentice ❒	Self-employed ❒	Casual ❒
Temporary ❒	Volunteer ❒	Principal/partner or relative of employer ❒	Other *(please specify)* ❒
Full time ❒	Student ❒	Fisher ❒	
Part time ❒	New entrant to workforce ❒	Hired on a contract basis ❒	

Incident information

5. Date and time of incident *(yyyy-mm-dd)* a.m. ❒ p.m. ❒ **OR**

6. Period of exposure resulting in occupational disease *(yyyy-mm-dd)* From To

7. Did worker report injury or exposure to employer? Yes ❒ No ❒

8. If yes, date reported to employer *(includes first aid)* *(yyyy-mm-dd)*

9. Name of person reported to

10. Describe how the incident happened

11. Describe the injury in detail *(what part of the body was injured)*

12. Side of body injured Left ❒ Right ❒ Bilateral ❒ Not applicable ❒

13. Describe the work incident location *(address, city, province)* and where incident occurred *(e.g. shop floor, lunchroom, parking lot)*

14. Did the injury(ies) or exposure result from a specific incident? Yes ❒ No ❒

15. Contributing factors — select AT LEAST ONE, and as many as applicable

Lifting ❒ _____ lb ❒ kg ❒	Struck ❒	Animal bite ❒
Overexertion ❒	Crush ❒	Assault ❒
Repetitive *(activity repeated over and over again)* ❒	Sharp edge ❒	Motor vehicle accident ❒
Slip or trip ❒	Fire or explosion ❒	Unsure/other *(please explain below)* ❒
Twist ❒	Harmful substance in the work environment ❒	
Fall ❒		

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Employer's Report of Injury or Occupational Exposure *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number *(if known)*

Social insurance number	Personal health number from BC CareCard

	Yes	No	Please explain
16. Were there any witnesses?	❒	❒	If yes,
17. Did the incident occur in British Columbia?	❒	❒	
18. Were the worker's actions at time of injury for the purpose of your business?	❒	❒	If no,
19. Did the incident occur on employer's premises or an authorized worksite?	❒	❒	If no,
20. Did the incident happen during the worker's normal shift?	❒	❒	If no,
21. Was the worker performing their regular duties at the time of the incident?	❒	❒	If no,
22. Are you aware of any previous pain or disability in the area of the worker's reported injury?	❒	❒	If yes,
23. Did the worker go to hospital, clinic, or visit a physician or qualified practitioner?	❒	❒	Date *(yyyy-mm-dd)*
If yes, please provide: Provider name *(if known)*			
24. Did the worker receive first aid?	❒	❒	Date *(yyyy-mm-dd)*
If yes, please provide: First aid attendant name *(if known)*			

25. Do you have any objections to the claim being allowed? Yes ❒ No ❒ *(If yes, please explain)*

Wage information

26. Did the worker miss any time from work beyond the date of injury or exposure? Yes ❒ No ❒

If NO WORK WAS MISSED and NO CHANGE to duties/pay, proceed to bottom of page to sign, date, and submit this report.
If WORK WAS MISSED or if duties/pay have been MODIFIED, please answer ALL questions on this form.

27. If work missed: Provide the base salary amount for this employment position at the time of injury
$ Hourly ❒ Weekly ❒ Bi-weekly ❒ Monthly ❒ Yearly ❒

28. Does worker receive other amounts of compensation in addition to base salary?
Vacation pay ❒ _____% Shift differential ❒ $_____ Overtime ❒ $_____
Does the worker receive vacation pay on every cheque? Room and board ❒ $_____ Other ❒ $_____
Yes ❒ No ❒ Tips and gratuities ❒ $_____

29. Provide the amount of **gross** earnings for the past 3 months or 12 weeks prior to the date of injury or exposure
$ 3 months ❒ 12 weeks ❒

30. Does the worker have a fixed-shift rotation? Yes ❒ No ❒

31. If no, please explain

32. If yes, show the normal work week by entering the paid hours

Sun	Mon	Tue	Wed	Thu	Fri	Sat

33. Did the worker continue to work past day of injury? Yes ❒ No ❒	34. Last day worked *(yyyy-mm-dd)*	35. Is worker continuing to receive their full salary? Yes ❒ No ❒
36. Number of hours scheduled to work on last day worked	37. Number of hours worked on last day	38. Number of hours paid by employer on last day worked

Return-to-work information

39. Has the worker returned to work? Yes ❒ No ❒

40. If **YES**: Date *(yyyy-mm-dd)*
Since the return to work, have the worker's duties, hours of work, work schedule, and/or rate of pay changed? Yes ❒ No ❒

41. If **NO**: Do you have any modified or transitional duties available? Yes ❒ No ❒ Have the modified or transitional duties been offered to the worker? Yes ❒ No ❒	42. If yes, please describe modified or transitional duties

Signature and report date

43. Employer signature	44. Employer title	45. Date of report *(yyyy-mm-dd)*

For personal assistance, please call our Claims Call Centre at 604 231-8888 or toll-free within BC at 1 888 967-5377.

The BC Legislature provides impartial advisers on all workers' compensation matters. For more information, call the Employers' Advisers Office at 604 713-0303, or toll-free within BC and Alberta at 1 800 925-2233. To locate the Employers' Advisers office nearest you, visit **www.labour.gov.bc.ca/eao/**

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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.