WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

APPLICATION FOR COMPENSATION AND REPORT OF INJURY OR OCCUPATIONAL DISEASE

Please answer all questions and complete this report in ink. Incomplete applications may have to be returned resulting in some delay in the processing of your claim. Please ensure that this report is signed and submitted by mail or fax.

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WORKER'S LAST NAME *(please print)* ❒ *Mr.* ❒ *Ms.* ❒ *Mrs.* ❒ *Miss*			**EMPLOYER'S NAME** *(as registered with WorkSafeBC (the Workers' Compensation Board))*	
First name(s)		Middle initial	Mailing address	
Mailing address			City	Postal code
City		Postal code	Location of plant or project where injury occurred	Postal code
Telephone number	Social insurance number	Date of birth *Month Day Year*	Type of business	
Weight	Height	Marital status ❒ Married ❒ Single ❒ Other	Worker's occupation	Employer's telephone number

1. Date and time of injury 20 , at ❒ A.M. ❒ P.M. OR period of exposure resulting in occupational disease From 20 , to 20	8. Name and address of physician or qualified practitioner who treated you? Include telephone number.
2. Injury was first reported to employer To ❒ First Aid ❒ Supervisor on 20 , at ❒ A.M. ❒ P.M.	9. Were there any witnesses? If YES, list their names and addresses on reverse side. ❒ YES ❒ NO
3. If employer was not notified immediately, give reason.	10. Did the injury occur on your employer's premises? If NO, explain on reverse side, giving exact location. ❒ YES ❒ NO
4. Describe fully what happened to cause the injury and mention all contributing factors; description of machinery, weight and size of objects involved, etc. OR in cases of occupational disease, describe fully how exposure occurred, mentioning any gases, vapours, dusts, chemicals, radiation, noise, source of infection or other causes. *(Use reverse side if necessary.)*	11. Was anyone else responsible for your injury? If YES, give name and address on reverse side. ❒ YES ❒ NO 12. Are you a relative of your employer or a partner or principal in the firm? If YES, explain on reverse side. ❒ YES ❒ NO 13. Have you had any previous pain or disability in the area of your present injury? If YES, explain on reverse side. ❒ YES ❒ NO
5. Did you receive first aid immediately? If NO, explain on reverse side. ❒ YES ❒ NO	14. Did you have any defect or disability before the injury (lost finger, blindness, deafness, restriction of movement etc.)? If YES, specify on reverse side. ❒ YES ❒ NO
6. State ALL injuries reported, indicating right or left if applicable.	15. Did you ever receive a cash award or pension from WorkSafeBC (WCB)? (DO NOT include any wage loss payment.) If YES, give claim number. ❒ YES ❒ NO
7. Did you lose any time from work beyond the day of injury? If YES, complete questions 16–25 below. ❒ YES ❒ NO	

16. Your gross earnings at time of injury? Enter one rate only. per hour $ per day $ per week $ per month $	21. Are you working now? If YES, specify date and time of return. ❒ YES ❒ NO 20 , at ❒ A.M. ❒ P.M.
17. If free room and/or meals are supplied in addition to above earnings, indicate daily value. $	22. Did you later attempt to work? If YES, specify dates and amount paid. ❒ YES ❒ NO
18. Do these earnings include rental of a vehicle or equipment? If YES, specify. ❒ YES ❒ NO	23. Show normal working week by entering hours worked each day. Sun. Mon. Tues. Wed. Thur. Fri. Sat.
19. Enter particulars of any payment or benefit made or to be made by employer for period of disability.	24. Enter normal working hours on day you last worked. From ❒ A.M. ❒ P.M. to ❒ A.M. ❒ P.M.
20. Date and time you last worked? 20 , at ❒ A.M. ❒ P.M.	25. Wages paid on your last day worked? $

PLEASE READ CAREFULLY

I declare all the information I have given on this report is true and correct, and I elect to claim compensation for the above-mentioned injuries or disease. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation benefits without advising WorkSafeBC (the Workers' Compensation Board). I authorize WorkSafeBC and the Workers' Compensation Appeal Tribunal to view or obtain a copy of records pertaining to my examination, treatment, history, and employment from any source whatsoever, including records of physicians, qualified practitioners, medical insurers, hospitals, and any employer. I understand the information is collected, used, and disclosed under the authority of the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. I acknowledge that WorkSafeBC may obtain and disclose information from my claim to my employer for the purpose of appeal, or may disclose such information to others in accordance with the law, including the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

Worker's signature	Date *Month Day Year*	Personal health number from your BC CareCard

☛ **ADDITIONAL INFORMATION CAN BE RECORDED ON PAGE 2 OF THIS REPORT.**
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 (WCB) claim number

Worker's personal health number from BC CareCard									

Additional information

Visit our web site at **WorkSafeBC.com**.

Mailing address for application and all claims correspondence: **WorkSafeBC**
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

Fax number: Local 604 233-9777 or toll-free within BC 1 888 922-8807.

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).

Other assistance

The Workers' Advisers Office is independent and separate from WorkSafeBC 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

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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