WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

WCB Accident Report: User's Guide

WCB Accident Report: User's Guide

The purpose of this *User's Guide* is to assist employers and workers to complete the *WCB Accident Report.* In this guide you will find an explanation for each question on the *WCB Accident Report.* The explanation may include clarification of what information is required by the WCB, examples of responses, and / or the reason why the WCB needs the information. Also included in the guide is a short glossary to explain some of the words found on the *WCB Accident Report.* The glossary can be found at the end of this guide.

Employers and workers can speed the claim process along by providing complete details about the accident, injury and earnings as soon as possible after the injury occurs. To ensure that you are providing the required information on the *WCB Accident Report*, please refer to this *User's Guide* as you complete the report.

At any time, if you have questions or comments, please feel free to contact us. We have answers…

Mainland Office

Workers' Compensation Board of Nova Scotia
5668 South Street
PO Box 1150
Halifax, NS B3J 2Y2

Telephone: (902) 491-8999 in Halifax
Toll free: 1-800-870-3331
Accident Reporting Facsimile: (902) 491-8001
General Facsimile: (902) 491-8002

Cape Breton Office

Workers' Compensation Board of Nova Scotia
336 Kings Road, Suite 117
Sydney, NS B1S 1A9

Telephone: (902) 563-2444 in Sydney
Toll free: 1-800-880-0003
Facsimile: (902) 563-0512

Virtual Office*

E-mail: info@wcb.gov.ns.ca
Web site: www.wcb.ns.ca

*At this time, we cannot accept *WCB Accident Reports* by email due to potential security and confidentiality issues with the Internet.

Table of Contents

Important points to remember:

- A *WCB Accident Report* must be submitted for all work-related accidents resulting in the need for medical attention and/or a loss of time from work or loss of earnings related to the injury. This includes injuries or illnesses that occurred over a period of time, as well as those caused by a single event. A *WCB Accident Report* is also required for all accidents resulting in death. If the claim being made is related to an occupational disease (for example, pneumonoconiosis or occupational hearing loss), then special accident reports for these conditions must be completed. Please contact the WCB directly for a copy of these reports by calling 1-800-870-3331 toll free in Nova Scotia, or (902) 491-8999 directly. These forms are also available on our web site at: www.wcb.ns.ca.

- Page 3 of the *WCB Accident Report* is required only when the worker has lost time from work or earnings.

- The *WCB Accident Report* must be submitted to the WCB within five business days of the employer, or any official representative of the employer, being notified of the accident, and it must reach the WCB within eight business days. If the WCB does not receive the report in that time period, a penalty will be applied to the employer's account.

- The *WCB Accident Report* must be signed by both the employer and the worker (where possible). Do not delay sending the *WCB Accident Report* simply because the worker is unable to sign it. If either party does not agree with the information provided on the report, the report must still be signed by both parties. Additional pages with the concerns outlined can be submitted with this report. A copy should be provided to the other party.

Page 1

Page 2

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Page 1

The information on the first page of the *WCB Accident Report* is required to ensure that the WCB can easily identify the employer and the worker during the claim process, to acknowledge that both parties have seen the information contained on the report, and to provide the appropriate acknowledgment needed to process the claim.

Employer Information
Completing this box provides the WCB with information so that the employer is easily identifiable. Please complete all the blanks.

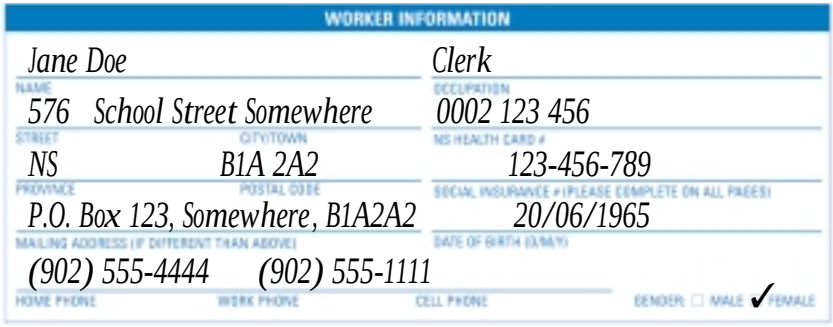
The company name is the legal name of the business. The trade name is the common name, the name which is known to the public, or the name under which most daily operations would be conducted. In some cases, the company name may be different from the trade name. For example, the company name might be 1234567 Nova Scotia Limited, but the trade name may be "Build It Construction Company."


EMPLOYER INFORMATION

1234567 Nova Scotia Limited — COMPANY NAME
12345 6789 NW 0001 — BUSINESS # (OR FIRM NUMBER)
123 AnyWhere Street — STREET
Somewhere — CITY/TOWN
J. Smith — CONTACT NAME
NS — PROVINCE
B1A 1A1 — POSTAL CODE
(902) 555 - 3333 — CONTACT PHONE
(902) 555-1111 — PHONE
(902) 555-2222 — FAX
buildit@ns.ca — EMAIL
Build It Construction Company — TRADE NAME (IF DIFFERENT THAN COMPANY NAME)

Worker Information
Completing this box provides the WCB with information so that the worker is easily identifiable. Please complete all the blanks.

The requirement to provide the worker's Social Insurance Number (SIN) assists the WBC to distinguish workers from others sharing the same name. Please note it on the top, right-hand corner of each page of the *WCB Accident Report.* This will ensure that, if the employer sends the earnings page at a later date, the WCB will be able to place the earnings information in the proper file and proceed with the claim.


WORKER INFORMATION

Jane Doe — NAME
Clerk — OCCUPATION
576 School Street Somewhere — STREET
0002 123 456 — NS HEALTH CARD #
NS — PROVINCE
B1A 2A2 — POSTAL CODE
123-456-789 — SOCIAL INSURANCE # (PLEASE COMPLETE ON ALL PAGES)
P.O. Box 123, Somewhere, B1A2A2 — MAILING ADDRESS (IF DIFFERENT THAN ABOVE)
20/06/1965 — DATE OF BIRTH (D/M/Y)
(902) 555-4444 — HOME PHONE
(902) 555-1111 — WORK PHONE
CELL PHONE
GENDER: ☐ MALE ✓ FEMALE

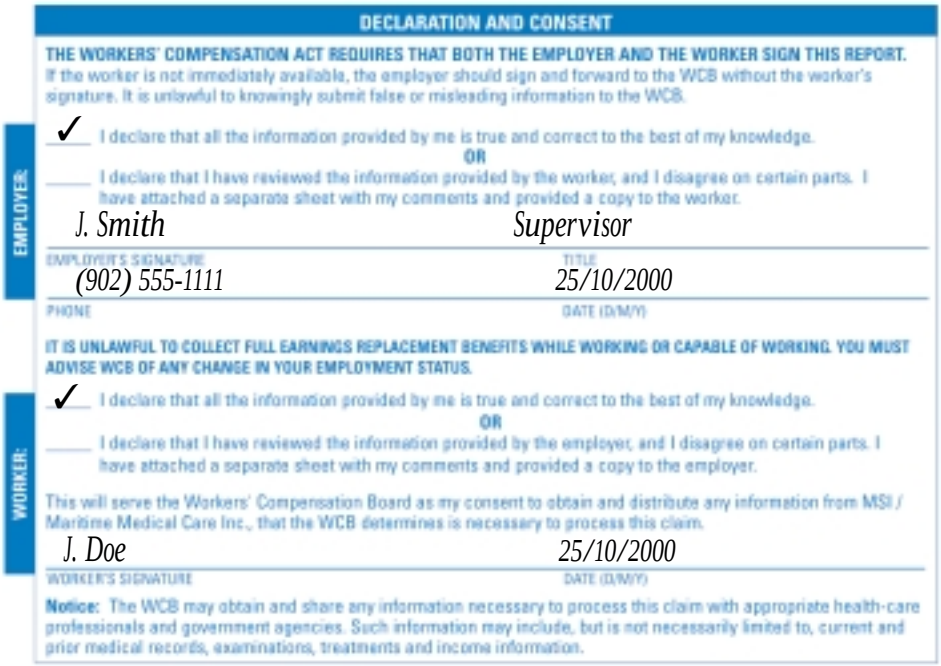
Declaration and Consent

This section serves four purposes. First, by providing their signatures, the employer and worker acknowledge that they have both participated in completing the *WCB Accident Report*. The WCB requires both signatures, although a claim should not be delayed simply because the worker's signature is not available. In some cases, the worker is unable to complete the report because of the nature or severity of the injury. In this instance the employer should complete the form and submit it to the WCB without the worker's signature. The worker's signature may be obtained later.

Second, this section provides employers and workers with the opportunity to indicate that they do not agree with the information (or any part thereof) provided on the report. If either party does not agree with the information provided, extra pages can be attached to the report with the concerns outlined. A copy should be provided to the other party.

The next part of this section is the consent of the worker, which grants the WCB permission to obtain and share information from MSI/Maritime Medical Care Inc., where required by the WCB to process a claim.

The last paragraph explains the WCB's right to obtain and share information with health-care providers and government for the purpose of processing the claim.



DECLARATION AND CONSENT

THE WORKERS' COMPENSATION ACT REQUIRES THAT BOTH THE EMPLOYER AND THE WORKER SIGN THIS REPORT.
If the worker is not immediately available, the employer should sign and forward to the WCB without the worker's signature. It is unlawful to knowingly submit false or misleading information to the WCB.

EMPLOYER:

✓ I declare that all the information provided by me is true and correct to the best of my knowledge.

OR

I declare that I have reviewed the information provided by the worker, and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the worker.

J. Smith — EMPLOYER'S SIGNATURE
Supervisor — TITLE
(902) 555-1111 — PHONE
25/10/2000 — DATE (D/M/Y)

IT IS UNLAWFUL TO COLLECT FULL EARNINGS REPLACEMENT BENEFITS WHILE WORKING OR CAPABLE OF WORKING. YOU MUST ADVISE WCB OF ANY CHANGE IN YOUR EMPLOYMENT STATUS.

WORKER:

✓ I declare that all the information provided by me is true and correct to the best of my knowledge.

OR

I declare that I have reviewed the information provided by the employer, and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the employer.

This will serve the Workers' Compensation Board as my consent to obtain and distribute any information from MSI / Maritime Medical Care Inc., that the WCB determines is necessary to process this claim.

J. Doe — WORKER'S SIGNATURE
25/10/2000 — DATE (D/M/Y)

Notice: The WCB may obtain and share any information necessary to process this claim with appropriate health-care professionals and government agencies. Such information may include, but is not necessarily limited to, current and prior medical records, examinations, treatments and income information.

Page 2

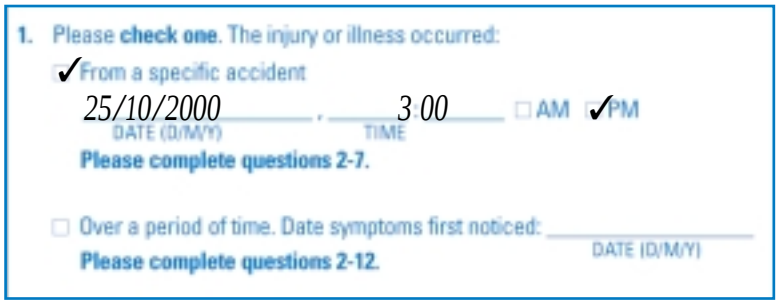
Your responses to Questions 1 to 7 on page 2 provide the WCB with information about the accident and the injury or illness.

Question 1
In this question, the WCB must determine if the worker's injury or illness resulted from a single event (e.g., fall) or over a period of time (e.g., an injury resulting from continuous use of a vibrating tool during the course of performing regular duties).

If the injury happened **from a single event**, please give the date of that incident.

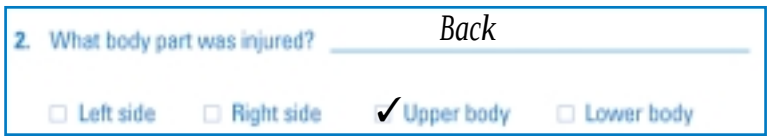
If the injury or illness happened **over a period of time** as a result of repetitive motion, or continuous use of vibrating equipment, provide the date when the symptoms were first noticed by the worker. If the worker doesn't know the date when the symptoms first began (date of onset), please estimate a date based on when the worker first visited a doctor, physiotherapist, or other medical professional for this particular condition.

If the claim is related to **an occupational disease** (e.g., pneumonoconiosis or occupational hearing loss), please do not complete this report. Special accident reports must be completed for these conditions. Please contact the WCB directly for a copy of these forms by calling 1-800-870-3331 toll free in Nova Scotia, or (902) 491-8999 directly. These forms are also available on our web site at www.wcb.ns.ca.


1. Please **check one**. The injury or illness occurred:
✓ From a specific accident
25/10/2000 (DATE (D/M/Y)) , 3 00 (TIME) ☐ AM ✓ PM
Please complete questions 2-7.
☐ Over a period of time. Date symptoms first noticed: _____ (DATE (D/M/Y))
Please complete questions 2-12.

Question 2
There are two reasons why the WCB needs this information. First, we must confirm the location of the injury so that we can help the worker recover and return to work. Second, we use this information to identify the claim and ensure that another claim has not already been opened for this incident.

Please indicate the part of the body that was injured. Where appropriate, state whether the injury is on the left or the right side of the body (e.g., left arm), and also whether the injury is on the upper or lower body (e.g., upper back).


2. What body part was injured? Back
☐ Left side ☐ Right side ✓ Upper body ☐ Lower body

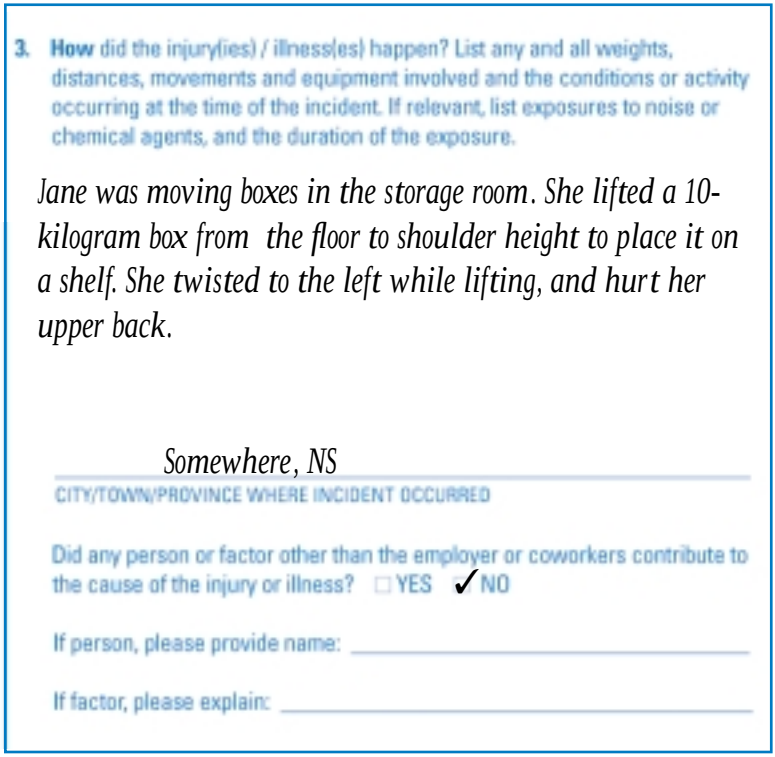
Note: The responses provided in the illustrations for Questions 2 to 7 reflect sample answers if an injury occurs as a result of a specific event. See the illustration for Question 1.

Question 3
The WCB must have details about the injury and accident to ensure that a claim is work-related and to determine the severity of the injury.

Provide a detailed description of how the accident happened, including what the worker was doing just before the injury/illness occurred. Also, please note any other people or factors (e.g., equipment, steel or wood planks, vehicles, electricity) involved in the accident. This allows the WCB to determine any third parties who may have had an impact on or responsibility for the injury. If the exact cause of the injury/illness is not known, please provide as much information as possible.

Example #1:
"Joe is employed as part of a paving crew. He uses a power jack to break up pavement. As a result of the continuous vibration of the jack, Joe is experiencing pain in his wrist which is increasing with time."

Example #2:
"Sally was delivering a package to a client by motor vehicle. While proceeding through a green light, her vehicle was struck by another vehicle. She is experiencing neck and shoulder pain."



3. **How** did the injury(ies) / illness(es) happen? List any and all weights, distances, movements and equipment involved and the conditions or activity occurring at the time of the incident. If relevant, list exposures to noise or chemical agents, and the duration of the exposure.

Jane was moving boxes in the storage room. She lifted a 10-kilogram box from the floor to shoulder height to place it on a shelf. She twisted to the left while lifting, and hurt her upper back.

Somewhere, NS
CITY/TOWN/PROVINCE WHERE INCIDENT OCCURRED

Did any person or factor other than the employer or coworkers contribute to the cause of the injury or illness? ☐ YES ✓ NO

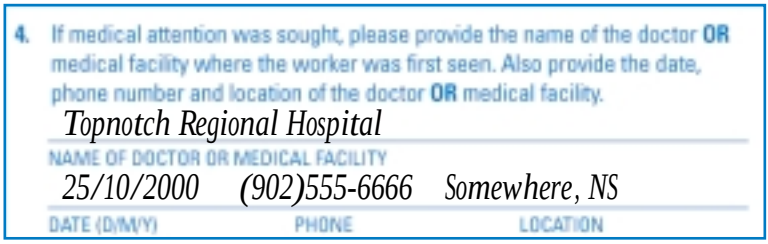
If person, please provide name: _____

If factor, please explain: _____

Question 4
This information lets the WCB know whether a medical report is expected. It is the worker's responsibility to ensure that all medical reports are sent to the WCB. However, the WCB may also request medical reports directly from appropriate sources.

Indicate the name of the first doctor or medical facility to treat the worker after the injury/illness occurred. Also note the date of the appointment/examination/treatment,

which may or may not be the same date as the accident. If available, please note the phone number and location of the doctor or medical facility.


4. If medical attention was sought, please provide the name of the doctor **OR** medical facility where the worker was first seen. Also provide the date, phone number and location of the doctor **OR** medical facility.

Topnotch Regional Hospital

NAME OF DOCTOR OR MEDICAL FACILITY

25/10/2000 *(902)555-6666* *Somewhere, NS*

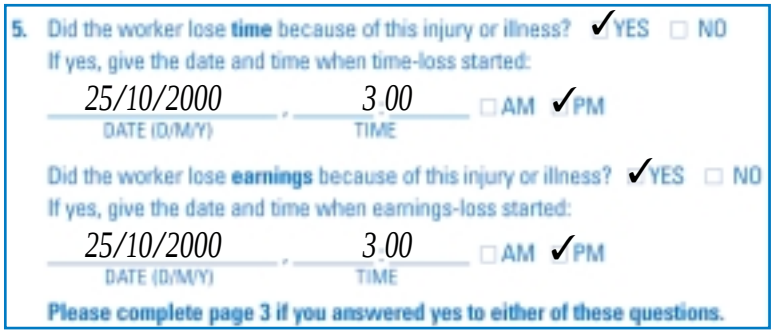
DATE (D/M/Y) PHONE LOCATION

Question 5

The WCB uses the dates when time loss and earnings loss began to know who and when to pay.

If the worker loses both time from work and earnings, then the WCB will pay benefits directly to the worker. If the worker loses only time from work because they are receiving sick pay or some other form of earnings from the employer, then the WCB will reimburse the employer.

Please note whether the worker lost time from work, and if so, whether the worker lost earnings as a result of this time away from work.


5. Did the worker lose **time** because of this injury or illness? ✓YES ☐ NO

If yes, give the date and time when time-loss started:

25/10/2000 DATE (D/M/Y) , *3 00* TIME ☐AM ✓PM

Did the worker lose **earnings** because of this injury or illness? ✓YES ☐ NO

If yes, give the date and time when earnings-loss started:

25/10/2000 DATE (D/M/Y) , *3 00* TIME ☐AM ✓PM

Please complete page 3 if you answered yes to either of these questions.

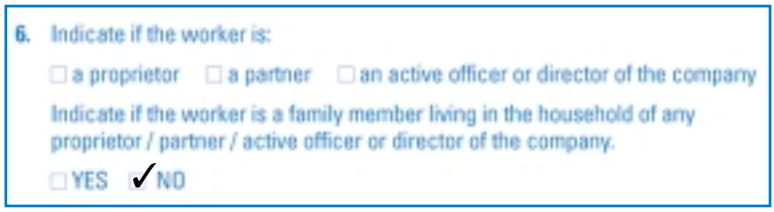
Question 6

This question is asking for clarification of the worker's status within the company. This is important because not all types of workers are covered by workers' compensation insurance.

For example:

- Certain proprietors, partners, officers and directors of a company may be covered, while others may not.
- Proprietors and partners are not covered by workers' compensation insurance, unless they have purchased special protection.
- Officers and directors of a company who are on the payroll are considered 'workers' and must be covered. Officers and directors who are not on the payroll are not covered by workers' compensation insurance.
- Family members living in the household of the proprietor, partners, officers or directors of the company are not automatically covered, unless special protection has been purchased in their name.

For more information about workers' compensation coverage, contact the Assessment Services Department, at (902) 491-8324**,** or toll free at 1-877-211-9267.


6. Indicate if the worker is:

☐ a proprietor ☐ a partner ☐ an active officer or director of the company

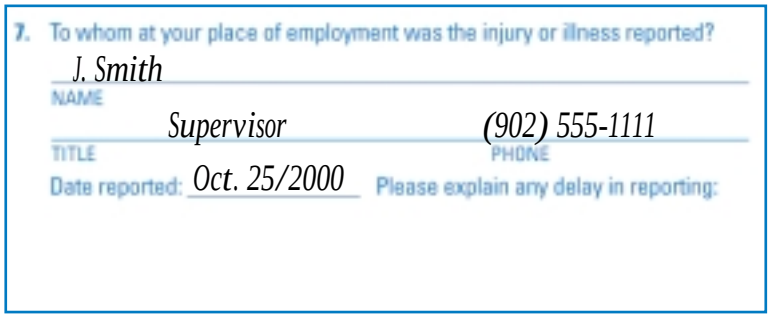
Indicate if the worker is a family member living in the household of any proprietor / partner / active officer or director of the company.

☐ YES ✓NO

Question 7

The WCB uses the date provided in this question to determine whether ***WCB Accident Reports*** are received on time. ***WCB Accident Reports*** must be submitted to the WCB within five business days of the accident being reported to the employer and received by the WCB within eight business days. Speedy reporting reduces delays in workers getting the benefits and services to which they are entitled.

Please indicate the name of the person within the organization (employer representative) to whom the accident was reported. Most importantly, note the date the accident was reported to the employer representative. If there is a delay in reporting to the WCB, the employer may also provide an explanation for the delay.


7. To whom at your place of employment was the injury or illness reported?

J. Smith

NAME

Supervisor *(902) 555-1111*

TITLE PHONE

Date reported: *Oct. 25/2000* Please explain any delay in reporting:

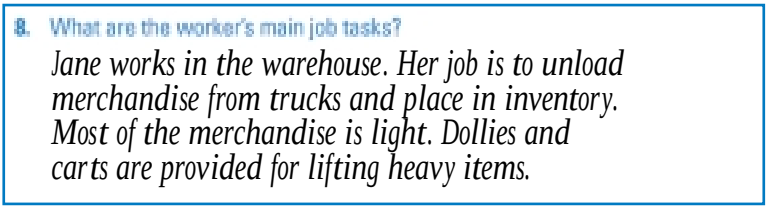
Page 2

Questions 8 to 12 on page 2 refer to injuries or illness that occur over a period of time. If you checked the box corresponding to "over a period of time" in Question 1, then you must complete this section. If you checked the box corresponding to "a specific incident", skip Questions 8 to 12 and go directly to Question 13.

Note: Up to this point in our illustrations we have been providing sample responses corresponding to an injury which happened as a result of a "specific accident." See Question 1 on page 5. If our response to Question 1 was an injury which "occurred over a period of time," then the following illustrations of Questions 8 - 12 provide sample responses appropriate to this situation. In reality, the employer must complete Questions 1 and 2 to 7, **or** Questions 1 and 8 to 12. Questions 13 to 21 are completed in either situation, if there is an earnings loss.

Question 8
Knowing the worker's main responsibilities is important to determine how the job tasks may have contributed to the injury and what treatment might be appropriate. For example, it may be necessary to change a worker's job responsibilities to reduce the likelihood of aggravating the injury again.

Please explain the worker's main job activities. You may attach an up-to-date and accurate job description.



Question 9
While any injury to a hand is important, an injury to the worker's dominant hand has significant effects on the worker's day-to-day life and performing even the simplest activities. In the case of a dominant-hand injury, the effect may be more significant. The response to this question helps the WCB measure the degree of impairment and the type and timing of treatment that may be required.

If the injury is to the worker's arm, wrist or hand, please indicate whether the worker is left- or right-handed.

Question 10
This question helps to determine whether the injury was caused by the activities the worker was performing at the time of the accident, or whether these activities aggravated a pre-existing injury.

Please provide the worker's position title and the length of time the worker has been doing this job. If the worker was doing another job within the past 90 days, then please list the title for this job as well.

Question 11
Knowing the amount of overtime worked just before the injury occurred, or when the symptoms were first noticed, is important to determine the cause of the injury (e.g., the activity itself, or the frequency of performing the activity) and the appropriate treatment or job changes to be made.

Please indicate the worker's overtime during the 90-180 days immediately before the injury.

11. How much overtime did the worker perform in the 90-180 days before this injury or illness occurred? *22 hours overtime in the last 4 weeks.*

Question 12
This question helps to determine whether it was the normal work routine which caused the injury, or whether the injury resulted from the worker doing something unusual or new. This will confirm the cause of the injury, but also assist the WCB and the worker to plan an appropriate recovery and return to work.

Please note the specific changes in the worker's activities or work volumes. For example, if the worker has taken on additional activities recently because a co-worker has been ill, on vacation or if the worker's job tasks have been changed, then note this here.

12. Have there been any changes in the worker's responsibilities in the past 90-180 days? (eg. changes in duties, changes in workload, a leave of absence). Please explain.

We had an increase in shipments resulting in our need to use storage space on the 2nd floor - usually storage is on the 1st floor. Jane had to climb stairs to access the 2nd floor storage. She did this approximately 25 times a day for one week before the injury.

Page 3

Your responses to Questions 13 to 21 on page 3 provide the WCB with the information required to calculate the worker's benefit, if eligible, and also help the WCB determine whether the worker is eligible for re-employment.

Question 13
This question helps determine whether a worker is eligible for re-employment.

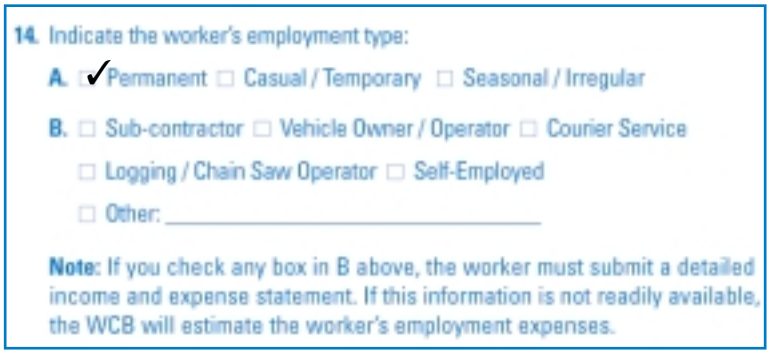
Please indicate whether the worker has been employed with this company for at least 12 months before the earnings loss for this injury began.

13. Has the worker been employed with this company for the 12 months preceding the earnings loss? ✓YES ☐ NO

Question 14
Confirming the type of employment for the worker assists the WCB in determining the worker's earnings-replacement benefit and helps to determine if there is a re-employment obligation.

Please complete category A or B, whichever applies to the worker. If the worker falls into any category in list B, a detailed statement of income and expenses must be submitted. This is because workers' compensation benefits do not include earnings-related expenses. If a statement is not provided, the WCB may estimate the worker's

income and expenses and base the level of benefits on this amount.


14. Indicate the worker's employment type:

A. ☑ Permanent ☐ Casual / Temporary ☐ Seasonal / Irregular

B. ☐ Sub-contractor ☐ Vehicle Owner / Operator ☐ Courier Service

☐ Logging / Chain Saw Operator ☐ Self-Employed

☐ Other: _____

Note: If you check any box in B above, the worker must submit a detailed income and expense statement. If this information is not readily available, the WCB will estimate the worker's employment expenses.

Question 15
This information is also used for re-employment decisions. A worker may be eligible for re-employment, if the worker has an employment pattern with the same employer.

Please confirm the date the worker was first employed with this employer. This may be recently, or five years ago, as might be the case with a seasonal worker who works with the same employer every summer.

> **Example:**
> Mary works every summer from May 1st to September 30th with the same employer. She originally started with this company in May 1997. This year, Mary began work, as usual, in May 2000. In August, Mary injured herself. In this example, the date required in Question 15 is May 1997, the date of her **first** employment with this employer.


15. If the worker is part-time, seasonal or casual, please indicate the date the **original** employment began. _____
DATE (D/M/Y)

Question 16
The information provided in this question is used to calculate the worker's benefit amount. Complete part A **or** B.

In part A of this question, please indicate the amount that would be considered the 'usual' or 'normal' gross pay for a worker. Also indicate the amount and the appropriate period for which the worker is normally paid.

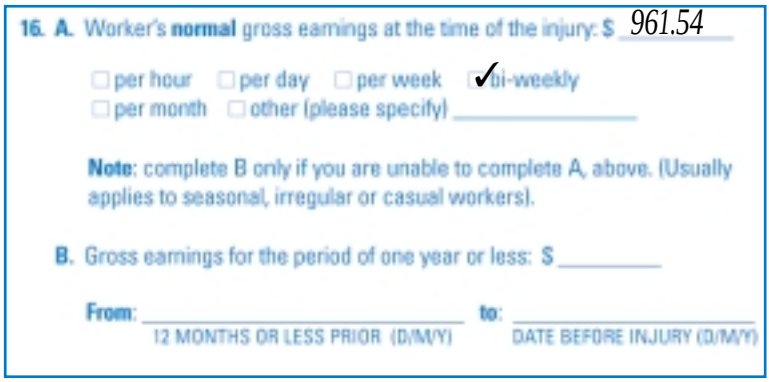
Some workers do not have regular earnings or work regular hours. If a worker has irregular employment, please provide a reasonable estimate of the worker's normal gross earnings. If the worker has irregular earnings or hours, it may be beneficial to discuss with the worker a reasonable estimate of what is 'normal' for that particular worker.

'Normal gross earnings' means any earnings paid to workers on a regular basis. In other words, please indicate what the worker is normally paid, and over what period of time.

Examples of normal earnings include the following types of earnings: **regular** salary or wages, **regular** overtime, commission, bonuses, vacation pay, profit sharing, tips and gratuities, taxable benefits, and other income included in `Employment Income' and `Other Employment Income' on the worker's individual tax return.

Part B of this question may also be used to determine the worker's benefit amount. It is directed at seasonal or casual workers, or workers who work irregular hours. For example, fishers who work a few weeks on and off during the fishing season.

In the example above, the employer would indicate the worker's earnings and start date for this particular fishing season. Provide the earnings information for the most recent employment period before the accident occurred. Also provide the start date of this employment period ending the day before the injury / illness occurred. For example, this fisher may have had $5,000 in gross earnings during this employment period from July 1, 2000 to Oct 24, 2000.


16. A. Worker's **normal** gross earnings at the time of the injury: $ 961.54

☐ per hour ☐ per day ☐ per week ☑ bi-weekly
☐ per month ☐ other (please specify) _____

Note: complete B only if you are unable to complete A, above. (Usually applies to seasonal, irregular or casual workers).

B. Gross earnings for the period of one year or less: $ _____

From: _____ **to:** _____
12 MONTHS OR LESS PRIOR (D/M/Y) DATE BEFORE INJURY (D/M/Y)

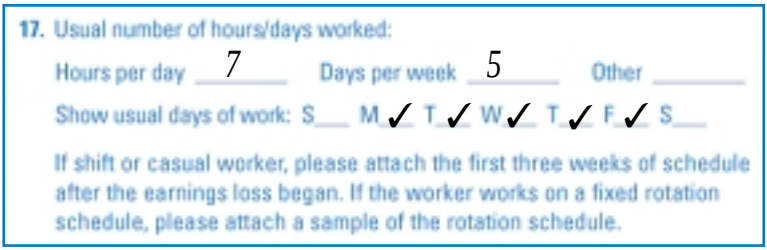
Question 17
This question helps determine the amount of the worker's WCB benefit and the worker's 2/5ths waiting period. Prior to receiving WCB earnings-replacement benefits, each worker must undergo a waiting period immediately after the injury. The waiting period is 2/5ths of the worker's usual work week. For this reason, the WCB must know the worker's usual hours and days worked.

Some workers have irregular hours because of the nature of their employment. Nurses, for example, perform shift work, and may have more hours in one week than the next. Carpenters are another example. They may work many hours during some weeks, and only a few hours during other weeks, depending on their contracts.

Please provide the worker's usual work hours or work days. Also indicate the days of the week the worker usually works. For workers with unusual work schedules, please give an estimate of the worker's average hours worked each week, and include, where possible, a schedule for the three weeks immediately following the day earnings loss began.

> **Example:**
> If a worker usually works five days a week, then the waiting period is two days (2/5 x 5). The WCB does not pay benefits for these two days.

Example:
If a worker usually works three 12-hour shifts a week, then they work 36 hours per week (3 x 12). Two-fifths of this amount is 14.4 hours (2/5 x 36). Therefore, the worker would not be paid by the WCB for 14.4 hours.


17. Usual number of hours/days worked:
Hours per day 7 Days per week 5 Other
Show usual days of work: S M ✓ T ✓ W ✓ T ✓ F ✓ S
If shift or casual worker, please attach the first three weeks of schedule after the earnings loss began. If the worker works on a fixed rotation schedule, please attach a sample of the rotation schedule.

Question 18
This information is used to reduce the worker's gross earnings to net earnings, which are used to calculate the worker's benefit amount.

The tax code tells the WCB how much income tax should be taken off the gross earnings. The worker's benefit amount is based on 75% of **net** earnings for the first 26 weeks, and 85% of **net** earnings thereafter.


18. Indicate the worker's tax deduction (TD) code: TD1

Question 19
This information helps the WCB determine from what point WCB benefits should be payable.

Please provide the number of hours scheduled on the day of the injury, how many hours worked before the injury, and how many hours for which the worker received pay from the employer.

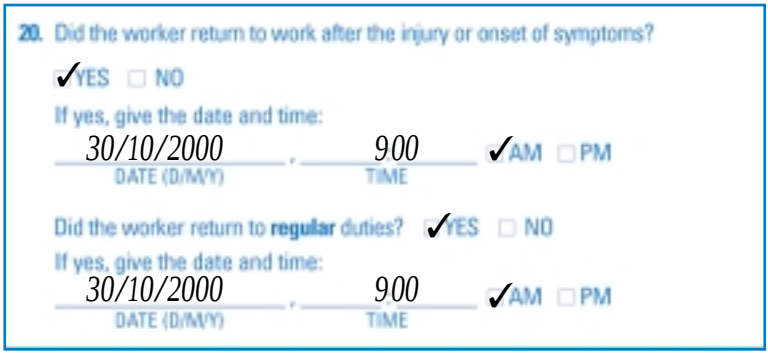
Example:
A worker is injured at 12 noon and goes to the hospital for treatment. The worker usually works seven hours during the day. Noon is the middle of their day, and they are not paid for their one-hour lunch period. Therefore, the WCB would be responsible to calculate benefits for that day based on four hours (from 1 pm to 5 pm), and then for seven hours a day thereafter, until the worker returns to work or benefits are discontinued.

However, there is a waiting period during which no WCB benefits are payable. This is 2/5ths of the worker's usual work week. Therefore, even though the WCB calculates benefits from the time the loss of earnings began, the first benefit cheque is reduced by a 2/5ths deductible. This amount is reimbursed if the worker's earnings loss lasts for more than five weeks.


19. Number of hours **scheduled** on day time/earnings loss began: 7
Number of hours **worked** on day time/earnings loss began: 5
Number of hours **paid** on day time/earnings loss began: 5

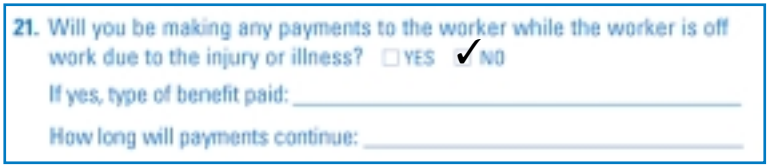
Question 20
The WCB must determine if the worker has returned to work, and whether the worker is receiving earnings. It is illegal for a worker to collect **full** WCB benefits when they have returned to work, regardless whether they have returned to full-time or part-time employment. If the worker has returned to modified work, WCB benefits must be adjusted by the amount of the worker's modified earnings. The worker must advise the WCB of any change in employment status.

Please indicate whether the worker has returned to work, and note the date and time the worker returned. Also note if the worker has resumed regular duties.


20. Did the worker return to work after the injury or onset of symptoms?
✓YES ☐ NO
If yes, give the date and time:
30/10/2000 (DATE (D/M/Y)) , 900 (TIME) ✓AM ☐PM
Did the worker return to **regular** duties? ✓YES ☐ NO
If yes, give the date and time:
30/10/2000 (DATE (D/M/Y)) , 900 (TIME) ✓AM ☐PM

Question 21
This information helps determine if the employer is paying the worker during the worker's time away from work. It is used to determine to whom the WCB should make the payment. Some employers pay their workers during their time away from work (e.g., top-up). In this case, the WCB reimburses the employer, rather than the worker. If the WCB knows when the payments from the employer will stop, the benefit will be forwarded directly to the worker, if the worker is still entitled to WCB benefits.

Please indicate whether the employer will pay the worker while the worker is away from work for this incident. Also note the type of benefit paid (e.g., regular pay, vacation pay, sick leave) and indicate when these payments will stop.


21. Will you be making any payments to the worker while the worker is off work due to the injury or illness? ☐YES ✓NO
If yes, type of benefit paid: _____
How long will payments continue: _____

The last page contains a short glossary provided to clarify terms found on the *WCB Accident Report* or in this *User's Guide*.

If you would like assistance completing the *WCB Accident Report*, or clarification of a particular question, please contact us. We have answers.

Glossary

Date of Onset
This is the date that symptoms were first noticed. Injuries that result from continuous use of vibrating equipment or repetitive motions don't happen suddenly. They occur over a period of time. The date of onset is the date when symptoms of an injury are first noticed. This may be difficult to recall, particularly if the injury occurred over a long period of time. If the date of onset is unknown, the date of the worker's first visit to a health-care professional for this purpose is appropriate.

Earnings-Replacement Benefits
The WCB provides financial assistance to workers who have had a work-related injury, and as a result, have lost time from work and earnings. Earnings-replacement benefits are based on the worker's net pre-accident earnings and adjusted for any wages the worker earns or is capable of earning after the accident.

Employer / Employer Representative
This is the person in the company to whom workers report accidents. This may be the owner, manager, medical officer, or another person specifically designated by the company to deal with accidents and/or complete the ***WCB Accident Report***.

Modified Duties
As a result of an injury, some workers may not be able to perform all of the same job activities they performed before their injury. However, in most cases, they can still return to work, but they may have to begin by performing modified duties. Modified duties might include the removal of certain duties the worker would usually perform, a change in the way or frequency that certain usual duties are performed, or different duties altogether.

Special Protection
Special protection is an optional insurance plan for self-employed proprietors and partners, and family members working for the employer and living in the employer's household. For more information about special protection, contact the WCB's Assessment Services Department at 491-8324 in Halifax, or toll free in Canada at 1-877-211-9267. You may also send an email to: assess@wcb.gov.ns.ca

Notes:

Mainland Office

Workers' Compensation Board of Nova Scotia
5668 South Street
PO Box 1150
Halifax, NS B3J 2Y2

Telephone: (902) 491-8999 in Halifax
Toll free: 1-800-870-3331
General Facsimile: (902) 491-8002
Accident Reporting Facsimile: (902) 491-8001

Cape Breton Office

Workers' Compensation Board of Nova Scotia
336 Kings Road, Suite 117
Sydney, NS B1S 1A9

Telephone: (902) 563-2444 in Sydney
Toll free: 1-800-880-0003
Facsimile: (902) 563-0512

Virtual Office*

E-mail: info@wcb.gov.ns.ca
Web site: www.wcb.ns.ca

*At this time, we cannot accept *WCB Accident Reports* by email due to potential security and confidentiality issues with the Internet.