WorkSafeBC

RESET

Worker's Report of Injury or Occupational Disease to Employer

Section 53(3) of the *Workers Compensation Act* requires that, where a worker is fit, and on request of the employer, they must provide the employer with particulars of the injury or occupational disease on a report prescribed by WorkSafeBC and supplied to the worker by the employer. This is the report prescribed.

- If requested by employer, please complete this report as it appears. Submit directly to employer. Do **NOT** submit to WorkSafeBC.
- This report should be completed by the injured worker if fit to do so. It can be completed by another individual for signature by the injured worker.
- If you need assistance with completing the form, please call WorkSafeBC Claims Call Centre at 604.231.8888 or toll-free throughout Canada at 1.888.967.5377, Monday to Friday, 8:00 a.m. to 4:30 p.m.

Worker information

WorkSafeBC claim number	Customer care number

Worker last name	First name	Middle intitial

Date of birth *(yyyy-mm-dd)*	Personal health number *(from BC CareCard)*	Social insurance number
- -		

Address line 1	Address line 2

City	Province/state	Country *(if not Canada)*	Postal code/zip

Home phone number *(include area code)*	Business phone number *(include area code)*	Business extension

Occupation	Gender
	☐ M ☐ F

Employer information

Employer organization name	

Type of business *(if known)*	Operating location *(if known)*

Address line 1	Address line 2

City	Province/state	Country *(if not Canada)*	Postal code/zip

Employer contact name	Employer phone number *(include area code)*	Extension

Incident information

1. Date and time of incident *(yyyy-mm-dd)* ☐ a.m. ☐ p.m. **OR**	2. Period of exposure resulting in occupational disease *(yyyy-mm-dd)* From To
3. My injury or disease was first reported to my employer on *(yyyy-mm-dd)* at ☐ a.m. ☐ p.m. *(please check one)* TO: ☐ First aid ☐ Supervisor ☐ Office ☐ Other *(specify)*	
4. Name of person reported to	

5. Did you receive first aid? ☐ Yes ☐ No ▶	6. Date of first aid *(yyyy-mm-dd)*	7. Name of first aid attendant
8. Did you go to the hospital, a medical clinic, or see a physician? ☐ Yes ☐ No ▶	9. If yes, name of physician or provider *(if known)*	
10. Address of physician or provider *(if known)*		
11. Are you aware of any recent pain or disability in the area of your reported injury? ☐ Yes ☐ No If yes, please explain		
12. Was protective equipment being used? ☐ Yes ☐ No	13. Were there any witnesses? ☐ Yes ☐ No	14. The supervisor in charge at the time of my injury was
15. Describe how the incident happened		16. Describe the injury in detail *(what part of the body was injured)*
		17. Side of body injured ☐ Left ☐ Right ☐ Both ☐ Not applicable

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Worker's Report of Injury or Occupational Disease to Employer (continued)

Worker last name	First name	Middle initial	WorkSafeBC claim number

Social insurance number	Personal health number from BC CareCard

Incident information (continued)

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

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

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

_____

_____

20. Did you or will you miss any time from work beyond the date of injury or exposure?

☐ Yes ☐ No

Signature and report date

21. Worker signature	22. Date of report *(yyyy-mm-dd)*

Additional information

The BC Legislature provides impartial advisers on all workers' compensation matters. The Workers' Advisers Office (WAO) provides free advice and assistance to workers and their dependants on disagreements they may have with WorkSafeBC decisions. WAO operates independently of WorkSafeBC. They have offices throughout the province and can be contacted at www.labour.gov.bc.ca/wab/ or by telephone: Richmond 604.713.0360, toll-free 1.800.663.4261; Victoria 250.952.4393, toll-free 1.800.661.4066; Kelowna 250.717.2096, toll-fee 1.800.663.6695.

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.