WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

INDEPENDENT OPERATOR'S 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. You may also wish to use the reverse side of this report or submit a separate letter.

Registration number under which you are registered with WorkSafeBC (the WCB)	Registration number	Location	Classification unit number	Coded by

Type of business	LAST NAME *(please print)* Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐
Employer's name *(as registered with WorkSafeBC)*	First name(s) / Middle initial
Mailing address	Home mailing address

City	Postal code	City	Postal code

Location of plant or project where injury occurred	Postal code	Date of birth *Month Day Year*	Home telephone number	Marital status Married ☐ Single ☐ Other ☐

Business telephone number	Occupation	Social insurance number	Height *Feet Inches*	Weight *lb.*

6/7

1A. Date and time of injury
20 , at A.M. ☐ P.M. ☐
OR
1B. period of exposure resulting in occupational disease
FROM 20 , TO 20

2A. Please describe fully what happened to cause the injury and mention all contributing factors: description of machinery, weight and size of objects involved, etc.
OR
2B. in cases of occupational disease, describe when and how exposure occurred, mentioning any gases, vapours, dusts, chemicals, radiation, noise, source of infection or other causes. Please explain fully.

3. What were you doing when this injury occurred?

4. Please state ALL injuries received at this time, indicating right or left if applicable.

5. Name and address of physician or qualified practitioner who treated this injury. Include telephone number, if known.

6. Names and addresses of persons who witnessed this injury. Include telephone numbers, if known.

7. Did the injury occur on the worksite? Please give exact location (city, town, place). YES ☐ NO ☐

8. Were your actions at time of this injury for the purpose of your business? If NO, please explain. YES ☐ NO ☐

9. Were your actions at time of this injury part of your regular work? If NO, please explain. YES ☐ NO ☐

10. Was anyone else responsible for your injury? If YES, please give name and address. YES ☐ NO ☐

11. Did you have any defect or disability before the injury (lost finger, blindness, deafness, restriction of movement, etc.)? YES ☐ NO ☐

12. Have you had any previous pain or disability in the area of this present injury? If YES, please specify. YES ☐ NO ☐

13. Did you ever receive a cash award or pension from WorkSafeBC (WCB)? If YES, please give claim number. Do NOT include wage loss payments. YES ☐ NO ☐

14. Did you lose any wages beyond the day of this injury? If YES, please specify date and time you stopped work. YES ☐ NO ☐
20 , at A.M. ☐ P.M. ☐

15. Are you working now? If YES, please specify date and time of return to work. YES ☐ NO ☐
20 , at A.M. ☐ P.M. ☐

16. Did you attempt to work during layoff? If YES, please specify dates and amount earned. YES ☐ NO ☐

17. Show normal working week by entering hours worked each day.

Sun.	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.

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 authorize WorkSafeBC (the Workers' Compensation Board) and Review Board to obtain or view, from any source whatsoever, including records of physicians, qualified practitioners, medical insurers or hospitals, a copy of records pertaining to examination, treatment, history and employment of the undersigned. Further, I acknowledge that WorkSafeBC may disclose information from my claim to my employer for purposes of appeal, or may disclose such infomation to others in accordance with the law, including the *Freedom of Information and Protection of Privacy Act*. I authorize WorkSafeBC to disclose information from my claim to the designated advocate of my union or similar association. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation without advising WorkSafeBC."

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

Date: SIGNED DATE

ADDITIONAL INFORMATION CAN BE RECORDED ON PAGE 2 OF THIS REPORT.
Please see the second page of this report 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.

Date: SIGNED DATE