WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

EMPLOYER'S REPORT OF INJURY OR OCCUPATIONAL DISEASE

Please answer all questions and complete this report in ink. The *Workers Compensation Act* requires the employer complete and submit this report within **three days** of a claimed injury, even if the employer is contesting the claim. Failure to do so is an offence and may result in the employer being charged with part of the cost of the claim. The Act requires WorkSafeBC (the Workers' Compensation Board) to collect detailed earnings information.

Please ensure that all information on this report is accurate, including the earnings data requested on the reverse side.

Registration number	Location	Classification Unit Number	Coded by

7

EMPLOYER'S NAME *(as registered with WorkSafeBC)*		**WORKER'S LAST NAME** *(please print)* Mr. Ms. Mrs. Miss	
Mailing address		First name(s)	Middle initial
City	Postal code	Mailing address	
Location of plant or project where injury occurred	Postal code	City	Postal code
Type of business	Employer's telephone number	Telephone number / Social Insurance number	Weight / Height
Name of contact person in your firm	Worker's occupation	Worker's personal health number from BC CareCard	Date of birth (Month Day Year)

1. Date and time of injury
   20 , at a.m./p.m.
   OR period of exposure resulting in occupational disease
   FROM 20 , TO 20

2. Injury was first reported to employer TO ☐ First Aid ☐ Supervisor
   ON 20 , at a.m./p.m. or

2A. Do you have any objections to the claim being accepted? If YES, please explain. If insufficient space, please attach a letter to this report. ☐ YES ☐ NO

3. 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

3A. 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.

4. Please state ALL injuries reported, indicating right or left if applicable.

5. Did worker receive first aid? If YES, please attach a copy of report 7A, First Aid Report. ☐ YES ☐ NO

6. Did worker attend a physician or qualified practitioner or clinic? If YES, please give name and address if known. ☐ YES ☐ NO

7. Did worker go to a hospital? If YES, please give name of hospital. ☐ YES ☐ NO

8. Do you know of any previous pain or disability in the area of the worker's present injury? If YES, please explain. ☐ YES ☐ NO ☐ UNKNOWN

9. Do you know of any defect or disability the worker had prior to the injury (e.g. lost finger, blindness, deafness, etc.) If YES, please specify. ☐ YES ☐ NO ☐ UNKNOWN

10. Were there any witnesses? If YES, please give name and address. ☐ YES ☐ NO ☐ UNKNOWN

10A. Do witnesses, if interviewed, confirm worker's statement? ☐ YES ☐ NO

11. Please indicate worker's employment status:
☐ Seasonal ☐ Casual ☐ Temporary
☐ Part Time ☐ Permanent, Full Time
☐ Other *(please provide details)*

12. Date worker started employment with you.

13. Date worker started this job.

14. Were worker's actions at time of injury for the purpose of your business? If NO, please explain. ☐ YES ☐ NO

15. Were they part of the worker's regular work? If NO, please explain. ☐ YES ☐ NO

Questions 16 to 29 inclusive are on the reverse side of this report.

☛ **Please see the reverse side 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	Worker's claim number

Worker's personal health number from BC CareCard									

16. Does worker operate as a subcontractor? If YES, please provide details. ☐ YES ☐ NO

17. Is worker a relative of employer or a partner or principal of the firm? If YES, please specify. ☐ YES ☐ NO

18. Was any person not in your employ responsible for this injury? If YES, please give details and name and address of such person. ☐ YES ☐ NO

19. Is alternate light duty or modified work available? ☐ YES ☐ NO

20. Will worker be off work beyond the day of injury? If YES, please complete questions 21 to 29 inclusive. ☐ YES ☐ NO

21. Please be accurate in supplying wage information/worker's gross earnings at the time of injury *(please enter one rate only).*

per hour $ per day $ per week $ per month $

22. Worker's exact gross earnings for:

3 months $_____ prior to date of injury

1 year $_____

23. Are any of the following additions to regular wages: *(please check appropriate box)*

☐ holiday pay ☐ room and/or meals
☐ rental ☐ vehicle allowance
☐ differential ☐ equipment
☐ shift premium ☐ other

If YES, please provide complete details.

24. Will any payment be made to the worker by your firm for period of disability (other than day of injury)? If YES, please specify. ☐ YES ☐ NO

25. Wages paid on last day worked. $

26. Show normal work week by entering hours worked each day. If regular worker, fill out Week 1 only.

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Week 1 ▶							
Week 2 ▶							

Does the worker work a fixed shift rotation? If YES, please provide the details, including the shift rotation start date. ☐ YES ☐ NO

27. Please enter hours on last day worked.

FROM a.m./p.m. TO a.m./p.m.

28. Date and time last worked after injury.

20 , at a.m./p.m.

29. Has employee returned to work? If YES, please specify date and time of return to work. ☐ YES ☐ NO

20 , at a.m./p.m.

Employer's signature	Title	Date

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, please contact WorkSafeBC's Freedom of Information Coordinator at 6951 Westminster Highway, Richmond BC, V7C 1C6, or telephone 604 279-8171.

For additional information on WorkSafeBC, please refer to our web site at **WorkSafeBC.com**

Mailing address for report and all claims correspondence: WorkSafeBC
PO Box 8940 Stn Terminal
Vancouver BC V6B 1H9

Fax number: Local 604 233-9722 or
toll free within BC 1 888 922-8803

Telephone information

Call Centre: 604 231-8888 or toll free within BC 1 888 967-5377.

Occupational Disease Services, call 604 276-3007 or toll free within BC 1 888 967-5377 (extension 3007).

Please Note: If you have concerns with this claim, please contact the officer handling the claim at the WorkSafeBC office to make known your objections or you may submit a letter detailing your specific concerns.

Impartial Advice on WorkSafeBC Claims – To ensure you have an opportunity to obtain impartial advice on WorkSafeBC claims matters, the BC legislature has provided impartial advisers. **Employers' Advisers** are available to provide independent advice or clarification on a WorkSafeBC claim related to your firm. For additional information on the Employers' Advisers, please refer to their web site at **www.labour.gov.bc.ca/eao/**.

Lower Mainland	Kelowna	Prince George	Victoria
604 713-0303 (Richmond)	250 717-2050	250 565-4285	250 952-4821
Toll free 1 800 925-2233	1 866 855-7575	1 888 608-8882	1 800 663-8783