WORKSAFE BC

APPLICATION FOR COMPENSATION AND REPORT OF INJURY OR OCCUPATIONAL DISEASE

For your convenience, WorkSafeBC offers three options for reporting a work-related injury and filing a claim:

1. **Call our Teleclaim Centre** – The fastest and easiest way to report an injury and file a **TIME-LOSS CLAIM** is to call us at **1.888.WORKERS** (1.888.967.5377). One of our knowledgeable representatives will take your information over the phone, explain the process, and refer you to services to aid with your recovery and return to work. Teleclaim is available Monday to Friday, from 8 a.m. to 6 p.m.
2. **Report your injury online** – Go to **worksafebc.com** and select "Report injury or illness" to input your information. You can submit your report online and, once submitted, you can follow the status of your claim online.
3. **Submit the paper form** – Clearly **PRINT** your information on the form below, sign it, and submit it by fax or mail.
   FAX: 604.233.9777 in Greater Vancouver, or toll-free within BC at **1.888.922.8807**
   MAIL: WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

For assistance, please call:

A. Claims Call Centre at 604.231.8888 or toll-free throughout Canada at 1.888.967.5377, Monday–Friday, 8 a.m. to 6 p.m.

B. The BC Legislature provides impartial advisers on all workers' compensation matters. The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. They have offices throughout the province and can be contacted at http://gov.bc.ca/workersadvisers or by telephone: Lower Mainland 604.713.0360, toll-free 1.800.663.4261; Vancouver Island 250.952.4393, toll-free 1.800.661.4066; Interior 250.717.2096, toll-free 1.800.663.6695.

Information about you

WorkSafeBC claim number *(if known)*	Customer care number *(if known)*

Worker last name	First name	Middle initial

Preferred first name	Gender M ☐ F ☐

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

Do you need an interpreter? Yes ☐ No ☐	Preferred language	What is your dominant hand? Left ☐ Right ☐	Height	Weight

Information about your employer

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 last name	First name	Employer phone number *(please include area code)*	Extension

Information about your employment

1. What is your occupation?	2. Have you been employed by this firm for less than 12 months? Yes ☐ No ☐	3. If yes, start date *(yyyy-mm-dd)*

4. At the time of injury, were you *(please check all that apply)*

Permanent ☐	Apprentice ☐	Self-employed ☐	Casual ☐
Temporary ☐	Volunteer ☐	Principal/partner or relative of employer ☐	Other *(please specify)* ☐
Full time ☐	Student ☐	Fisher ☐	
Part time ☐	New entrant to workforce ☐	Hired on a contract basis ☐	

5. How many employers do you have?

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Application for Compensation and Report of Injury or Occupational Disease *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number

Social insurance number	Personal health number from BC CareCard

Incident information

6. Date and time of incident *(yyyy-mm-dd)*
a.m. ☐ p.m. ☐ **OR**

7. Period of exposure resulting in occupational disease *(yyyy-mm-dd)*
From To

8. Have you reported the injury/exposure to your employer? Yes ☐ No ☐

9. The injury or disease was first reported to employer on *(yyyy-mm-dd)*

(please check one)
TO: First aid ☐ Supervisor ☐ Office ☐
Other ☐ *(please specify)*

10. Name of person reported to

11. If no, provide reason for not reporting to your employer

12. Describe how the incident happened

13. Describe the injury in detail *(what part of the body was injured)*

14. Side of body injured
Left ☐ Right ☐ Both ☐ Not applicable ☐

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

16. Did your injury(ies) or exposure result from a specific incident? Yes ☐ No ☐

17. Contributing factors – select AT LEAST ONE, and as many as applicable

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

18. Were there any witnesses?
Yes ☐ No ☐

19. Did the incident occur in British Columbia?
Yes ☐ No ☐

20. Were your actions at time of injury for your employer's business?
Yes ☐ No ☐

21. Did the incident occur on employer's premises or an authorized worksite?
Yes ☐ No ☐

22. Did the incident occur during your normal shift?
Yes ☐ No ☐

23. Were you performing your regular work duties at the time of the incident?
Yes ☐ No ☐

24. Did you receive first aid?
Yes ☐ No ☐ Date *(yyyy-mm-dd)*

If yes, please provide first aid attendant name *(if known)*

25. Did you go to hospital, clinic, or visit a physician or qualified practitioner?
Yes ☐ No ☐ Date *(yyyy-mm-dd)*

If yes, please provide provider name *(if known)*

If yes, please provide provider address *(if known)*

26. Prior to this incident, did you have any recent pain or disability in the area of your injury?
Yes ☐ No ☐

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Application for Compensation and Report of Injury or Occupational Disease *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number

Social insurance number	Personal health number from BC CareCard

Wage information

27. Did you miss work beyond the date of injury or exposure? Yes ☐ No ☐

If NO WORK WAS MISSED and NO CHANGE to duties/pay, proceed to bottom of page to sign, date, and submit this report. If WORK WAS MISSED or if duties/pay have been MODIFIED, please answer ALL questions on this form.

28. What is your current **base salary** amount for this employment position at the time of injury $ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

29. Please provide total gross amount of earnings you receive from other employers $ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

30. Do you receive other amounts of compensation in addition to **base salary**? Yes ☐ No ☐

Do you receive vacation pay on every cheque? Yes ☐ No ☐

If yes, vacation pay _____%

Please select check boxes for any of the following amounts you receive in addition to **base salary** AND provide the amount:

Tips and gratuities ☐ $ _____ Room and board ☐ $ _____

Shift differential ☐ $ _____ Other ☐ $ _____

Overtime ☐ $ _____

31. If you are disabled from work, will you continue to receive:

Base salary? Yes ☐ No ☐

Other amounts of compensation in addtion to **base salary**? Yes ☐ No ☐

Will you continue to receive vacation pay on every cheque? Yes ☐ No ☐

If yes, vacation pay _____%

Please select check boxes for any of the following amounts you will continue to receive in addition to **base salary** AND provide the amount:

Tips and gratuities ☐ $ _____ Room and board ☐ $ _____

Shift differential ☐ $ _____ Other ☐ $ _____

Overtime ☐ $ _____

32. Provide your **gross** earnings for the past 3 months or 12 weeks prior to the date of injury or exposure $ 3 months ☐ 12 weeks ☐

33. Do you work a fixed-shift rotation? Yes ☐ No ☐

34. If no, please explain

35. If yes, show your normal work week by entering the paid hours

Sun	Mon	Tue	Wed	Thu	Fri	Sat

36. Did you continue to work past day of injury? Yes ☐ No ☐

37. Last day worked *(yyyy-mm-dd)*

38. Number of hours you were scheduled to work on last day worked

39. Number of hours you worked on last day worked

40. Number of hours paid by your employer on last day worked

Return-to-work information

41. Have you returned to work? Yes ☐ No ☐

42. If **YES**: Date you returned to work *(yyyy-mm-dd)*

Since the return to work, has there been any change to your work duties or will there be any change to your hours of work, your work schedule, or your rate of pay? Yes ☐ No ☐

43. If **NO**: Does your employer have any **modified** or **transitional** duties available? Yes ☐ No ☐

Have the modified or transitional duties been offered to you? Yes ☐ No ☐

44. If yes, please describe modified or transitional duties

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*.

45. Worker signature

46. Date of report *(yyyy-mm-dd)*

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.