

# Worker's Report of Injury or Occupational Disease to Employer


**RESET**

## ► Submit directly to employer. Do NOT submit to WorkSafeBC.

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.
- 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 this 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 a.m. to 6 p.m. PST.

## Worker's information

|                                         |  |                                                   |  |                                           |  |                                                                         |  |
|-----------------------------------------|--|---------------------------------------------------|--|-------------------------------------------|--|-------------------------------------------------------------------------|--|
| WorkSafeBC claim number (if known)<br>X |  |                                                   |  | Customer care number (if known)<br>X      |  |                                                                         |  |
| Worker's last name<br>X                 |  |                                                   |  | First name<br>X                           |  | Middle initial<br>X                                                     |  |
| Date of birth (yyyy-mm-dd)<br>        - |  | Personal health number (BC Services/CareCard)<br> |  | Social insurance number<br>               |  |                                                                         |  |
| 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<br><input type="checkbox"/> Male <input type="checkbox"/> Female |  |

## Employer's information

|                                                        |                      |                                                             |                            |
|--------------------------------------------------------|----------------------|-------------------------------------------------------------|----------------------------|
| Employer's organization name<br>School District No. 85 |                      |                                                             |                            |
| Type of business (if known)<br>Education               |                      | Operating location (if known)                               |                            |
| Address line 1<br>Box 90                               |                      | Address line 2                                              |                            |
| City<br>Port Hardy                                     | Province/State<br>BC | Country (if not Canada)                                     | Postal code/Zip<br>V0N 2P0 |
| Employer's contact name<br>Darby Gildersleeve          |                      | Employer's phone number (include area code)<br>250 949 8155 | Extension<br>222           |

## Incident information

|                                                                                                                                                     |                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Date and time of incident (yyyy-mm-dd)<br><input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <b>OR</b>                                  | 2. Period of exposure resulting in occupational disease (yyyy-mm-dd)<br>From To                                                                                                                                  |
| 3. Date and time my injury or disease was first reported to my employer (yyyy-mm-dd)<br><input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | My injury or disease was first reported to (please check one)<br><input type="checkbox"/> First aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Other (specify) |

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|                             |                 |                                                        |                              |
|-----------------------------|-----------------|--------------------------------------------------------|------------------------------|
| Worker's last name<br>X     | First name<br>X | Middle initial<br>X                                    | WorkSafeBC claim number<br>X |
| Social insurance number<br> |                 | Personal health number (BC Services card/CareCard)<br> |                              |

## Incident information (continued)

|                                                                                                                                                                |                                                                                           |                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------|--|
| 4. Name of person reported to                                                                                                                                  |                                                                                           |                                     |  |
| 5. Did you receive first aid?<br><input type="checkbox"/> Yes <input type="checkbox"/> No ▶                                                                    | 6. Date of first aid (yyyy-mm-dd)                                                         | 7. Name of first aid attendant<br>X |  |
| 8. Did you go to the hospital, a medical clinic, or see a physician?<br><input type="checkbox"/> Yes <input type="checkbox"/> No ▶                             | 9. If yes, name of physician or provider (if known)<br>X                                  |                                     |  |
| 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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No ▶          | If yes, please explain                                                                    |                                     |  |
| 12. Was protective equipment being used?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                           | 13. Were there any witnesses?<br><input type="checkbox"/> Yes <input type="checkbox"/> 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<br><input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable |                                                                                           |                                     |  |

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|                             |                 |                                                        |                              |
|-----------------------------|-----------------|--------------------------------------------------------|------------------------------|
| Worker's last name<br>X     | First name<br>X | Middle initial<br>X                                    | WorkSafeBC claim number<br>X |
| Social insurance number<br> |                 | Personal health number (BC Services card/CareCard)<br> |                              |

## 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 <b>at least one</b> , and as many as applicable                                                        |                                                                    |                                                 |                                                              |
| <input type="checkbox"/> Lifting _____                                                                                                   | <input type="checkbox"/> lb                                        | <input type="checkbox"/> kg                     | <input type="checkbox"/> Animal bite                         |
| <input type="checkbox"/> Overexertion                                                                                                    | <input type="checkbox"/> Struck                                    | <input type="checkbox"/> Crush                  | <input type="checkbox"/> Assault                             |
| <input type="checkbox"/> Repetitive (activity repeated over and over again)                                                              | <input type="checkbox"/> Sharp edge                                | <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Unsure/other (please explain below) |
| <input type="checkbox"/> Slip or trip                                                                                                    | <input type="checkbox"/> Fire or explosion                         |                                                 |                                                              |
| <input type="checkbox"/> Twist                                                                                                           | <input type="checkbox"/> Harmful substance in the work environment |                                                 |                                                              |
| <input type="checkbox"/> Fall                                                                                                            |                                                                    |                                                 |                                                              |
| 20. Did you or will you miss any time from work beyond the date of injury or exposure?                                                   |                                                                    |                                                 |                                                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                 |                                                                    |                                                 |                                                              |

## Signature and report date

|                        |                                 |
|------------------------|---------------------------------|
| 21. Worker's 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/](http://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-free 1.800.663.6695.

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.