



# 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.**

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.

<b>Worker information</b>		WorkSafeBC claim number	Customer care number
Worker last name		First name	Middle initial
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
Occupation			Gender M <input type="checkbox"/> F <input type="checkbox"/>

## 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 (please include area code)	Extension

## Incident information

1. Date and time of incident (yyyy-mm-dd)		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) (please check one)			
at a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> TO: First aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Other <input type="checkbox"/> (please specify)			
4. Name of person reported to			
5. Did you receive first aid?		6. Date of first aid (yyyy-mm-dd)	
Yes <input type="checkbox"/> No <input type="checkbox"/>		7. Name of first aid attendant	
8. Did you go to the hospital, a medical clinic, or see a physician? Yes <input type="checkbox"/> No <input type="checkbox"/>		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 <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain			
12. Was protective equipment being used?		13. Were there any witnesses?	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
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 <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable <input type="checkbox"/>	



# 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*)

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

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"/>		Assault <input type="checkbox"/>
Repetitive ( <i>activity repeated over and over again</i> ) <input type="checkbox"/>	Crush <input type="checkbox"/>		Motor vehicle accident <input type="checkbox"/>
Slip or trip <input type="checkbox"/>	Sharp edge <input type="checkbox"/>		Unsure/other ( <i>please explain below</i> ) <input type="checkbox"/>
Twist <input type="checkbox"/>	Fire or explosion <input type="checkbox"/>		_____
Fall <input type="checkbox"/>	Harmful substance in the work environment <input type="checkbox"/>		_____

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 ( <i>yyyy-mm-dd</i> )
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**Additional information**

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 [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 1 866 881-1188.

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.