WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

The worker requests a copy of the employer's report to the Workers' Compensation Board.

WORKER'S REPORT OF INJURY OR OCCUPATIONAL DISEASE TO EMPLOYER

6 A

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.

This report should be completed by the injured worker if fit to do so. It should never be completed by anyone else for signature by the injured worker.

Section 53(3) of the *Workers Compensation Act* requires that where a worker is fit, and on a request of the employer, they must provide the employer with particulars of the injury or occupational disease on a report prescribed by the Board and supplied to the worker by the employer. This is the report prescribed.

Please complete this report as it appears. It is prohibited and an offence to add any questions to this report.

If you do not know the answers to any of the following questions, please print "don't know" in the appropriate space.

WORKER'S LAST NAME *(please print)* *Mr. Ms.* *Mrs. Miss*			**EMPLOYER'S NAME** *(as registered with the Board)*	
First name(s)		Middle initial	Mailing address	
Mailing address			City	Postal code
City		Postal code	Location of plant or project where injury occurred	Postal code
Telephone number	Social insurance number	Date of birth *Month Day Year*	Type of business	
Weight	Height *Feet Inches*	Marital status ❒ Married ❒ Single ❒ Other	Worker's occupation	Employer's telephone number

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

2. My injury or disease was first reported to my employer on *(please check one)*
20 at a.m./p.m. TO ❒ First Aid ❒ Supervisor ❒ Office ❒ Or:

3. *(please check one)*
❒ I received first aid ❒ I did not receive first aid

4. Name of First Aid Attendant

5. Name and address of attending physician or qualified practitioner *(if any)*

6. Was protective equipment being used?
❒ Yes ❒ No

7. Name of witnesses *(if any)*

8. The supervisor in charge at the time of my injury was

9. The following describes what happened to cause the injury and includes contributing factors: description of any machinery or objects involved, etc.

OR

The following (in cases of occupational disease) describes how exposure occurred. Gases, vapours, dusts, chemicals, radiation, noise, source of infection or other causes are mentioned as appropriate.

(please use reverse side of report if necessary)

10. All apparent injuries received at this time are as follows: Specify part(s) of body injured, indicating right or left.

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 the Workers' Compensation Board (the '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 the Board 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 the Board 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 the Board."

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

☛ **ADDITIONAL INFORMATION CAN BE RECORDED 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	WCB claim number

Worker's personal health number from BC CareCard									

Additional information

Personal information on this form is collected for the purposes of administering a worker's compensation claim by the Board in accordance with the ***Workers Compensation Act*** and the ***Freedom of Information and Protection of Privacy Act***. For further information, please contact the Board's Freedom of Information Coordinator at 6951 Westminster Highway, Richmond, BC, V7C 1C6, or telephone 604 279-8171.

Visit our web site at **www.worksafebc.com**

Mailing address for application and all claims correspondence: Workers' Compensation Board of BC
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 the WCB 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