

APPLICATION FOR COMPENSATION AND REPORT OF INJURY OR OCCUPATIONAL DISEASE

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.

WORKER'S LAST NAME (please print) <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss		EMPLOYER'S NAME (as registered with WorkSafeBC (the Workers' Compensation 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	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	Worker's occupation
		Employer's telephone number	
1. Date and time of injury 20 , at <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		8. Name and address of physician or qualified practitioner who treated you? Include telephone number.	
OR period of exposure resulting in occupational disease From 20 , to 20			
2. Injury was first reported to employer To <input type="checkbox"/> First Aid <input type="checkbox"/> Supervisor on 20 , at <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		9. Were there any witnesses? If YES, list their names and addresses on reverse side. <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. If employer was not notified immediately, give reason.		10. Did the injury occur on your employer's premises? If NO, explain on reverse side, giving exact location. <input type="checkbox"/> YES <input type="checkbox"/> NO	
4. Describe fully what happened to cause the injury and mention all contributing factors; description of machinery, weight and size of objects involved, etc. OR in cases of occupational disease, describe fully how exposure occurred, mentioning any gases, vapours, dusts, chemicals, radiation, noise, source of infection or other causes. (Use reverse side if necessary.)		11. Was anyone else responsible for your injury? If YES, give name and address on reverse side. <input type="checkbox"/> YES <input type="checkbox"/> NO	
5. Did you receive first aid immediately? If NO, explain on reverse side. <input type="checkbox"/> YES <input type="checkbox"/> NO		12. Are you a relative of your employer or a partner or principal in the firm? If YES, explain on reverse side. <input type="checkbox"/> YES <input type="checkbox"/> NO	
6. State ALL injuries reported, indicating right or left if applicable.		13. Have you had any previous pain or disability in the area of your present injury? If YES, explain on reverse side. <input type="checkbox"/> YES <input type="checkbox"/> NO	
7. Did you lose any time from work beyond the day of injury? If YES, complete questions 16-25 below. <input type="checkbox"/> YES <input type="checkbox"/> NO		14. Did you have any defect or disability before the injury (lost finger, blindness, deafness, restriction of movement etc.)? If YES, specify on reverse side. <input type="checkbox"/> YES <input type="checkbox"/> NO	
		15. Did you ever receive a cash award or pension from WorkSafeBC (WCB)? (DO NOT include any wage loss payment.) If YES, give claim number. <input type="checkbox"/> YES <input type="checkbox"/> NO	

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16. Your gross earnings at time of injury? Enter one rate only. per hour \$ per day \$ per week \$ per month \$		21. Are you working now? If YES, specify date and time of return. <input type="checkbox"/> YES <input type="checkbox"/> NO 20 , at <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
17. If free room and/or meals are supplied in addition to above earnings, indicate daily value. \$		22. Did you later attempt to work? If YES, specify dates and amount paid. <input type="checkbox"/> YES <input type="checkbox"/> NO	
18. Do these earnings include rental of a vehicle or equipment? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, specify.		23. Show normal working week by entering hours worked each day. Sun. Mon. Tues. Wed. Thur. Fri. Sat.	
19. Enter particulars of any payment or benefit made or to be made by employer for period of disability.		24. Enter normal working hours on day you last worked. From <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. to <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	
20. Date and time you last worked? 20 , at <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		25. Wages paid on your last day worked? \$	

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*.

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

ADDITIONAL INFORMATION CAN BE RECORDED ON PAGE 2 OF THIS REPORT.
Please see page 2 for telephone and fax numbers.



Worker's last name	First name	Middle initial	Social insurance number	WorkSafeBC (WCB) claim number
				Worker's personal health number from BC CareCard

Additional information

Visit our web site at WorkSafeBC.com.

Mailing address for application and all claims correspondence: **WorkSafeBC**
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 WorkSafeBC 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

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.