



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 4 p.m.
- 2. Online form** – Go to **WorkSafeBC.com** and select “Forms” then select “Worker.” Type in your details, print the form, and submit it by fax or mail.
- 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:

- Claims Call Centre at 604 231-8888 or toll-free throughout Canada at 1 888 967-5377, Monday–Friday, 8:00 a.m. to 4:30 p.m.
- 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/ 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

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 <input type="checkbox"/> F <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/>	Preferred language	What is your dominant hand? Left <input type="checkbox"/> Right <input type="checkbox"/>		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 <input type="checkbox"/> No <input type="checkbox"/>	3. If yes, start date (yyyy-mm-dd)
4. At the time of injury, were you (please check all that apply)		
Permanent <input type="checkbox"/>	Apprentice <input type="checkbox"/>	Self-employed <input type="checkbox"/>
Temporary <input type="checkbox"/>	Volunteer <input type="checkbox"/>	Principal/partner or relative of employer <input type="checkbox"/>
Full time <input type="checkbox"/>	Student <input type="checkbox"/>	Fisher <input type="checkbox"/>
Part time <input type="checkbox"/>	New entrant to workforce <input type="checkbox"/>	Hired on a contract basis <input type="checkbox"/>
5. How many employers do you have?		





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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)		7. Period of exposure resulting in occupational disease (yyyy-mm-dd)	
		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> OR	From _____ To _____
8. Have you reported the injury/exposure to your employer? Yes <input type="checkbox"/> No <input type="checkbox"/>		9. The injury or disease was first reported to employer on (yyyy-mm-dd)	
		(please check one) TO: First aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Other <input type="checkbox"/> (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 <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable <input type="checkbox"/>			
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 <input type="checkbox"/> No <input type="checkbox"/>			
17. 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"/>		Assault <input type="checkbox"/>	
Repetitive (activity repeated over and over again) <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 (please explain below) <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"/>		
18. Were there any witnesses? Yes <input type="checkbox"/> No <input type="checkbox"/>		19. Did the incident occur in British Columbia? Yes <input type="checkbox"/> No <input type="checkbox"/>	
20. Were your actions at time of injury for your employer's business? Yes <input type="checkbox"/> No <input type="checkbox"/>		21. Did the incident occur on employer's premises or an authorized worksite? Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. Did the incident occur during your normal shift? Yes <input type="checkbox"/> No <input type="checkbox"/>		23. Were you performing your regular work duties at the time of the incident? Yes <input type="checkbox"/> No <input type="checkbox"/>	
24. Did you receive first aid? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>			



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

Worker last name	First name	Middle initial	WorkSafeBC claim number
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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

<p>30. Do you receive other amounts of compensation in addition to base salary? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you receive vacation pay on every cheque? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, vacation pay _____%</p> <p>Please select check boxes for any of the following amounts you receive in addition to base salary AND provide the amount:</p> <p>Tips and gratuities <input type="checkbox"/> \$ _____ Room and board <input type="checkbox"/> \$ _____</p> <p>Shift differential <input type="checkbox"/> \$ _____ Other <input type="checkbox"/> \$ _____</p> <p>Overtime <input type="checkbox"/> \$ _____</p>	<p>31. If you are disabled from work, will you continue to receive: Base salary? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Other amounts of compensation in addition to base salary? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Will you continue to receive vacation pay on every cheque? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, vacation pay _____%</p> <p>Please select check boxes for any of the following amounts you will continue to receive in addition to base salary AND provide the amount:</p> <p>Tips and gratuities <input type="checkbox"/> \$ _____ Room and board <input type="checkbox"/> \$ _____</p> <p>Shift differential <input type="checkbox"/> \$ _____ Other <input type="checkbox"/> \$ _____</p> <p>Overtime <input type="checkbox"/> \$ _____</p>
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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)
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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.