WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

REFERENCE GUIDE

Form 6 – Application for Compensation and Report of Injury or Occupational Disease

This guide has been created to assist workers when completing Form 6

Form 6		
Form Field Question	**Response Type**	**Description of Information Requested**
Information about you…		
WorkSafeBC claim number	Alpha/numeric	This is the claim number assigned and provided to you, when your report of injury is received by WorkSafeBC. *Please note: the fastest and easiest way to report an injury and file a claim is to call the WorkSafeBC Teleclaim Centre at 1 888 967-5377, Monday to Friday from 8 a.m. to 4 p.m.*
Customer care number	Numeric	This number is assigned by WorkSafeBC. It is yours for life. You may have more than one injury claim during your lifetime, each with a unique claim number but your customer care number will never change.
Worker last name	Text	Your surname.
First name	Text	Your first name.
Middle initial	Text	Your middle initial.
Preferred first name	Text	The first name you prefer to use or be known by.
Gender	Check box (x)	Select M or F.
Date of birth	Numeric	Your date of birth.
Personal health number (from BC CareCard)	Numeric	This is the 10-digit number on your BC CareCard.
Social insurance number	Numeric	SIN number as indicated on your SIN card.
Address line 1	Text/numeric	Your mailing address.
Address line 2	Text/numeric	Additional mailing address line, if required.
City	Text	City for your mailing address.
Province/state	Text	Province or State for your mailing address.
Country (if not Canada)	Text	Complete ONLY if your mailing address is outside of Canada.
Postal code/zip	Text/numeric	Postal Code or Zip Code for your mailing address.
Home phone number (& area code)	Numeric	Your home phone number.
Business phone number (& area code)	Numeric	Your business phone number, if you have one.
Business extension	Numeric	Extension for business phone above, if applicable.
Do you need an interpreter	Check box (x)	Please indicate “yes” or “no”
Preferred language	Text	Please indicate which language you prefer to use.
What is your dominant hand?	Check box (x)	Please indicate “left” or “right”
Height	Text/numeric	Please provide your height indicating either ft./in. or cm.
Weight	Text/numeric	Please provide your weight indicating either lb. or kg.
Information about your employer…		
Employer organization name	Text/numeric	The name of your employer’s firm.
Type of business (if known)	Text	This refers to the nature of your employer’s business. E.g. logging, retail, hospital, etc.
Operating location (if known)	Numeric	The operating location where the injury occurred.
Address line 1	Text/numeric	The address where your employer wants to receive correspondence regarding this claim.
Address line 2	Text/numeric	Additional mailing address line, if required.

City	Text	City for the mailing address provided.
Province/State	Text	Province or State in which mailing address is located.
Country (if not Canada)	Text	This field only needs to be filled if the Employer's mailing address is outside of Canada.
Postal code/zip	Text/numeric	Postal Code or Zip Code for Employer's mailing address.
Employer contact last name	Text	This is the name of the PRIMARY individual in your employer's firm that WorkSafeBC should deal with regarding your claim.
First name	Text	As above.
Employer contact telephone (& area code)	Numeric	Business phone for person above
Extension	Numeric	Extension for business phone above, if applicable
Information about your employment…		
1. What is your occupation?	Text	What is the job that you do (e.g. welder, nurse, bus driver, etc.) NOT your job title (e.g. Welder Supervisor; Senior Nurse Advisor III, etc.).
2. Have you been employed by this firm for less than 12 months	Check box (x)	This refers to less than 12 months *from the date of hire*.
3. If yes, start date	Numeric	Date you were hired for this position.
4. ***At the time of the injury were you (check all that apply)*** - *Permanent* - *Temporary* - *Full time* - *Part time* - *Apprentice* - *Volunteer* - *Student* - *New entrance to workforce* - *Self employed* - *Principal/partner or relative of employer* - *Fisher* - *Hired on a contract basis* - *Casual* - *Other (please specify)*	Check box (x)	Please check all that are correct for your position at the time the incident or exposure occurred.
5. How many employers do you have?	Numeric	How many employers are you working for?
Incident information…		
6. Date and time of incident	Numeric	The exact date the incident occurred and the approximate time of the incident, indicating am or pm.
7. Period of exposure resulting in occupational disease	Numeric	If applicable, indicate the period of time (from/to) that the exposure occurred.
8. Have you reported the injury/ exposure to your employer?	Check box (x)	Please indicate "yes" or "no"
9. The injury or disease was first reported to employer on (yyyy-mm-dd. TO: First aid; Supervisor, Office; Other	Numeric, Check box (x) Text	Indicate the exact date the incident was reported to the employer. Select (x) who the incident was reported to; if "other" provide a brief explanation.
10. Name of person reported to	Text	The name of the person to whom the incident was first reported. This could be the First Aid attendant, your supervisor, manager, etc.
11. If no, provide reason for not reporting to your employer.	Text	Please provide an explanation for not reporting the injury/disease to your employer.
12. Describe how the incident happened	Text	A detailed explanation or description of *how* the incident occurred.

13. Describe the injury in detail (what part of the body was injured)	Text	Provide a description of the *injuries*, clearly indicating which part(s) of the body were injured.
14. Side of body injured (left; right; both; not applicable)	Check box (x)	Indicate which side of your body was injured.
15. Describe the work incident location (address, city, province) and where the incident occurred (e.g. shop floor, lunchroom, parking lot)	Text	Please provide as much information about the incident location, including the exact work location where you were assigned to work on date of injury, as well as the exact location within the worksite where incident occurred.
16. Did your injury (ies) or exposure result from a specific incident?	Check box (x)	Please indicate "yes" or "no"
17. ***Contributing factors – select AT LEAST ONE, and as many as applicable*** - *Lifting; _____lb. kg* - *Overexertion* - *Repetitive (activity repeated over and over again)* - *Slip or trip* - *Twist* - *Fall* - *Struck* - *Crush* - *Sharp edge* - *Fire or explosion* - *Harmful substance in the work environment* - *Animal bite* - *Assault* - *Motor vehicle accident* - *Unsure/other (pls. explain)*	Check box (x)	Please select as many check boxes as applicable for the incident or exposure being reported.
18. Were there any witnesses?	Check box (x)	Please indicate "yes" or "no"
19. Did the incident occur in British Columbia?	Check box (x)	Please indicate "yes" or "no"
20. Were your actions at time of injury for the purpose of your employer's business?	Check box (x)	Please indicate "yes" or "no"
21. Did the incident occur on employer's premises or an authorized worksite?	Check box (x)	Please indicate "yes" or "no"
22. Did the incident happen during your normal shift?	Check box (x)	Please indicate "yes" or "no"
23. Were you performing your regular duties at the time of the incident?	Check box (x)	Please indicate "yes" or "no"
24. Did you receive First Aid - *Date* - *If yes, please provide first aid attendant name (if known)*	Check box (x) Numeric Text	Please indicate "yes" or "no" Indicate date First Aid was provided. Even if First Aid provided did not occur at your place of employment, please provide the name of the attendant.
25. Did you go to hospital, clinic, or visit a physician or qualified practitioner? - *Date* - *If yes, please provide provider name (if known)*	Check box (x) Numeric Text	Please indicate "yes" or "no". It is helpful to have the Provider name, Clinic name or Hospital where you were treated, so that appropriate medical forms can be obtained regarding injury or exposure.
26. Prior to this incident, did you have any recent pain or disability in the area of your injury?	Check box (x)	Please indicate "yes" or "no"

Wage information…		
27. Did you miss any time from work beyond the date of injury or exposure?	Check box (x)	Please indicate "yes" or "no"
*28. What is your current **base salary** amount for this employment position at the time of injury?*	Numeric	This refers to the base earnings you receive BEFORE any additional amounts of compensation earnings are provided, as outlined in question 28.
29. Please provide total gross amount of earnings you receive from other employers	Numeric	This is the total amount of earnings, including base salary PLUS other amounts of compensation, paid to you by other employers.
*30. **Do you receive other amounts of compensation in addition to base salary?*** *Do you receive vacation pay on every cheque?* *If yes, vacation pay %* *Please select check boxes for any of the following amounts you receive in addition to base salary AND provide the amount for each* - *Shift differential* - *Room and board* - *Tips and gratuities* - *Overtime* - *Other*	Check box (x) Check box (x) Numeric Check box (x) & Numeric	Please provide all types and amounts of compensation you receive in addition to the base salary. E.g. Shift premium might be an additional amount received for the type of job performed on a given shift. For example a person may be acting as a first aid attendant, so an additional hourly amount would be paid. "Other" if you are paid another type of compensation, please select "other" and provide brief explanation below that check box.
*31. **If you are disabled from work, will you continue to receive:*** *Base salary?* *Other amounts of compensation in addition to base salary?* *Will you receive vacation pay on every cheque?* *If yes, vacation pay %* *Please select check boxes for any of the following amounts you will receive in addition to base salary AND provide the amount for each* - *Shift differential* - *Room and board* - *Tips and gratuities* - *Overtime* - *Other*	Check box (x) Check box (x) Check box (x) Numeric Check box (x) & Numeric	Please provide all types and amounts of compensation you receive in addition to the base salary. E.g. Shift premium might be an additional amount received for the type of job performed on a given shift. For example a person may be acting as a first aid attendant, so an additional hourly amount would be paid. "Other" if you are paid another type of compensation, please select "other" and provide brief explanation below that check box.
*31. Provide your **gross earnings** for the past 3 months or 12 weeks prior to the date of injury or exposure.*	Numeric Check box (x)	Please provide the amount *before* deductions and *include* all other amounts of compensation, as outlined in question 28. Indicate if you are providing 3 month or 12 week earnings information.
33. Do you have a fixed shift rotation?	Check box (x)	Please indicate "yes" or "no". If there is a shift pattern that repeats within 5 cycles or less, this is considered a fixed shift rotation. Some examples of a fixed shift rotation are: - 4 days on; 4 days off = 1 cycle - 8 hours/day Monday to Friday = 1 cycle

34. If no, please explain.	Text	If your work shift is not repeated within 5 cycles or less, please explain the shift rotation and cycles.
35. If yes, show the normal work week by entering the paid hours	Numeric	If yes to #30, please show the hours paid for one cycle on the one-week chart provided.
36. Did you continue to work past day of injury?	Check box (x)	Please indicate "yes" or "no".
37. Last day worked.	Numeric	Please provide the date you last worked; it may be the date of the incident; it may be a date later than the incident.
38. Number of hours you were scheduled to work on last day worked?	Numeric	How many hours were you scheduled to work on the last day you worked?
39. Number of hours you worked on last day worked.	Numeric	How many hours did you work on the last day you worked?
40. Number of hours paid by your employer on last day worked.	Numeric	How many hours did your employer pay you for, on the last day you worked?
Return-to-work information…		
41. Have you returned to work?	Check box (x)	Please indicate "yes" or "no".
40 If YES: • *Date* • *Since the return to work, have your duties, hours of work, work schedule and/or rate of pay changed?*	 Numeric Check box (x)	 If yes, what was the date you returned to work? If yes, please indicate by selecting "yes" or "no", if any changes to the your duties, hours of work, work schedule and/or rate of pay have occurred.
41. If NO: • *Does your employer have any modified or transitional duties available* • *Have the modified or transitional duties been offered to you?*	 Check box (x) Check box (x)	 Please indicate "yes" or "no" If yes, was selected above please advise if those duties have been offered to you, by selecting "yes" or "no".
***42.** If yes, please describe the modified or transitional duties.*	Text	Please explain how the duties have been modified in any way for your return to work. This includes changes to hours per day, days per week, as well as the modification of tasks performed.
43. Worker signature	Text	Mandatory
45. Date of report	Numeric	Mandatory