

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

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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	Numeric	This is the 10-digit number on your BC CareCard.	
CareCard)	NI	CINI according to disease days constructed and	
Social insurance number	Numeric Text/numeric	SIN number as indicated on your SIN card.	
Address line 1 Address line 2	Text/numeric	Your mailing address. 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	
Country (Il Hot Canada)	Text	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.	

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City	Text	City for the mailing address provided.
Province/State	Text	Province or State in which mailing address is
1 Tovinos, Glato	TOXE	located.
Country (if not Canada)	Text	This field only needs to be filled if the Employer's
Country (Il riot Gariada)	TOXE	mailing address is outside of Canada.
Postal code/zip	Text/numeric	Postal Code or Zip Code for Employer's mailing
Postal Code/Zip	1 ext/Hullienc	address.
Employer contact last name	Text	This is the name of the PRIMARY individual in your
Employer contact last hame	TOAL	employer's firm that WorkSafeBC should deal with
		regarding your claim.
First name	Text	As above.
Employer contact telephone (& area	Numeric	
, , ,	Numenc	Business phone for person above
code) Extension	Numeric	Extension for husiness phone shows if applicable
	Numenc	Extension for business phone above, if applicable
Information about your employment	Tout	M/bat is the ish that you do /a a wolder awar has
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
O Have you been smallered to the first	Objects to a ()	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
	N1	hire.
3. If yes, start date	Numeric	Date you were hired for this position.
4. At the time of the injury were you	Check box (x)	Please check all that are correct for your position at
(check all that apply)		the time the incident or exposure occurred.
♣ 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 (1)		
Other (please specify)		
5. How many employers do you have?	Numeric	How many employers are you working for?
Incident information	1	
6. Date and time of incident	Numeric	The exact date the incident occurred and the
		approximate time of the incident, indicating am or
	ļ	pm.
7. Period of exposure resulting in	Numeric	If applicable, indicate the period of time (from/to)
occupational disease		that the exposure occurred.
8. Have you reported the injury/	Check box (x)	Please indicate "yes" or "no"
exposure to your employer?		
9. The injury or disease was first	Numeric,	Indicate the exact date the incident was reported to
reported to employer on (yyyy-mm-dd.	Check box (x)	the employer. Select (x) who the incident was
TO: First aid; Supervisor, Office; Other	Text	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	Text	Please provide an explanation for not reporting the
to your employer.		injury/disease to your employer.
12. Describe how the incident happened	Text	A detailed explanation or description of how the
		incident occurred.

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

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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?	Check box (x)	Please provide all types and amounts of compensation you receive in addition to the base salary.
Do you receive vacation pay on every cheque?	Check box (x)	
If yes, vacation pay %	Numeric	
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	Check box (x) & Numeric	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.
♣ Tips and gratuities♣ Overtime♣ Other		"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?	Check box (x) Check box (x) Check box (x)	Please provide all types and amounts of compensation you receive in addition to the base salary.
If yes, vacation pay %	Numeric	
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	Check box (x) & Numeric	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.
♣ Tips and gratuities♣ Overtime♣ Other		"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 <i>before</i> deductions and <i>include</i> 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

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35. If yes, show the normal work week by entering the paid hours 36. Did you continue to work past day of injuny? 37. Last day worked. Numeric Numeric Please indicate "yes" or "no". Please provide the date you last worked; it may be a date later than the incident. Numeric Numeric Numeric How many hours were you scheduled to work on last day worked? Number of hours you worked on last day worked. Number of hours paid by your employer on last day worked. Numeric How many hours did you work on the last day you worked? Numeric How many hours did you work on the last day you worked? Numeric How many hours did you work on the last day you worked? Numeric How many hours did you work on the last day you worked? Numeric How many hours did you remployer pay you for, on the last day you worked? Numeric How many hours did your employer pay you for, on the last day you worked? Numeric How many hours did your employer pay you for, on the last day you worked? Numeric How many hours did your employer pay you for, on the last day you worked? Numeric How many hours did you work on the last day you worked? Numeric How many hours did your employer pay you for, on the last day you worked? Numeric How many hours did your employer pay you for, on the last day you worked? Numeric How many hours did your employer pay you for, on the last day you worked? Numeric How many hours did your employer pay you for, on the last day you worked? Numeric How many hours did your employer pay you for, on the last day you worked? Please indicate "yes" or "no". Check box (x) 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. Please indicate "yes" or "no" Check box (x) Please indicate "yes" or "no" Please indicate "yes" or "no". The yes, please describe the modified or transitional duties available If yes, whas selected above please advise if those duties have been offered to you, by selecting "yes" or "no". Please explain	34. If no, please explain.	Text	If your work shift is not repeated within 5 cycles or
26. Did you continue to work past day of injury? 37. Last day worked. 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? 41. Have you returned to work, now changed? 41. If NO: 42. If yes, please describe the modified or transitional duties. 43. Worker signature Check box (x) Please indicate "yes" or "no". Please provide the date you last worked; it may be the date of the incident. Numeric date of the incident; it may be a date later than the incident. How many hours were you scheduled to work on the last day you worked? How many hours did you work on the last day you worked? How many hours did your employer pay you for, on the last day you worked? Check box (x) Please indicate "yes" or "no". If yes, what was the date you returned to work? Check box (x) 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 changes to the your duties, hours of work, work schedule and/or rate of pay have occurred. Check box (x) Please indicate "yes" or "no". Please indicate "yes" or "no". Check box (x) Please indicate "yes" or "no". The please indicate "yes" or "no". Check box (x) Please indicate "yes" or "no". Please indicate "yes" or "no". Check box (x) Please indicate "yes" or "no". Check box (x) All the notified or transitional 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.			less, please explain the shift rotation and cycles.
36. Did you continue to work past day of injury? 37. Last day worked. Numeric Num		Numeric	
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40. Number of hours paid by your employer on last day worked. Return-to-work information 41. Have you returned to work? 40 If YES: ↓ Date ↓ Since the return to work, have your duties, hours of work, work schedule and/or rate of pay changed? 41. If NO: ↓ Does your employer have any modified or transitional duties available ↓ Have the modified or transitional duties or transitional duties. ↓ If yes, what was the date you returned to work? Lif 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. Check box (x) ↓ Please indicate "yes" or "no" Check box (x) Please indicate "yes" or "no" Check box (x) Flease indicate "yes" or "no" Check box (x) Flease indicate "yes" or "no" Check box (x) Flease 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 Numeric How many hours did your employer pay you for, on the last day you worked? Please indicate "yes" or "no". Check box (x) If yes, was selected above please advise if those duties have been offered to you, by selecting "yes" or "no". Flease 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.	39. Number of hours you worked on last	Numeric	How many hours did you work on the last day you
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