WorkSafe
WORKERS' COMPENSATION BOARD OF BC

PLEASE SEND THIS REPORT TO THE OFFICE COVERING WORKER'S WORKPLACE AREA. PLEASE NOTE: FACSIMILE (FAX) COPIES ARE ACCEPTABLE AT ALL WCB OFFICES IN BC.

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 mailed to the WCB office serving your workplace area.

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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	Marital status ❒ Married ❒ Single ❒ Other	Worker's occupation	Employer's telephone number

1. Date and time of injury 20 , at A.M./P.M. OR period of exposure resulting in occupational disease From 20 , to 20	8. Name and address of physician or qualified practitioner who treated you? Include telephone number.
2. Injury was first reported to employer on 20 , at A.M./P.M. To ❒ First Aid ❒ Supervisor	9. Were there any witnesses? If YES, list their names and addresses on reverse side. ❒ YES ❒ 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. ❒ YES ❒ 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. ❒ YES ❒ NO
	12. Are you a relative of your employer or a partner or principal in the firm? If YES, explain on reverse side. ❒ YES ❒ NO
	13. Have you had any previous pain or disability in the area of your present injury? If YES, explain on reverse side. ❒ YES ❒ NO
5. Did you receive first aid immediately? If NO, explain on reverse side. ❒ YES ❒ 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. ❒ YES ❒ NO
6. State ALL injuries reported, indicating right or left if applicable.	15. Did you ever receive a cash award or pension from the BC Board? (DO NOT include any wage loss payment.) If YES, give claim number. ❒ YES ❒ NO
7. Did you lose any time from work beyond the day of injury? If YES, complete questions 16–25 below. ❒ YES ❒ NO	

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. ❒ YES ❒ NO 20 , at A.M./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. ❒ YES ❒ NO
18. Do these earnings include rental of a vehicle or equipment? If YES, specify. ❒ YES ❒ NO	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 A.M./P.M. to A.M./P.M.
20. Date and time you last worked? 20 , at A.M./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 authorize the Workers' Compensation Board (the 'Board') and Workers' Compensation Appeal Tribunal 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 information 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.

Worker's last name	First name	Middle initial	Social insurance number	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 the **Lower Mainland and Vancouver Island/Terrace** Call Centre at 604 231-8888 or toll free within BC 1 888 967-5377.

Call the **BC Interior and North** Call Centre at 250 717-4301 or toll free within BC 1 888 922-6622.

Occupational Disease Services, call 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