



EMPLOYER'S REPORT OF INJURY OR OCCUPATIONAL DISEASE

As an employer, the *Workers Compensation Act* requires you to submit this report **within three days** of an injury to one of your workers, even if you disagree with the claim. By submitting your report promptly, you avoid penalties and delays in the adjudication of the claim. Please report using one of the following options:

- Online — The quickest and easiest option:** The online screen application customizes questions to the worker's injury. You can save your report and update it later with new information. Once submitted, you can follow the status of the claim online. Go to WorkSafeBC.com and select "Report an injury or illness."
- Fillable PDF form:** Type in your details online, print the form, and submit it by FAX or MAIL. Go to WorkSafeBC.com and select "Report an injury or illness."
- Paper form:** Clearly PRINT details, sign the form, 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

WorkSafeBC claim number (if known)

Employer information

| | | | |
|----------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------|----------------------------------|
| Employer's name (as registered with WorkSafeBC) Vancouver Island West School District 84 | | Type of business Education | |
| WorkSafeBC account number 118924 | Classification unit number | | Operating location number |
| Employer address line 1 (mailing) PO Box 100 | | Employer contact last name James | First name Anne |
| Employer address line 2 (mailing) | | Employer contact telephone (and area code) 250-283-2241 | Extension 250-283-7352 |
| City Gold River | Province/state BC | Employer payroll contact last name Loranger | First name Bonnie |
| Country (if not Canada) | Postal code/zip V0P 1G0 | Employer payroll contact telephone (and area code) 250-283-2241 | Extension 250-283-7352 |

Worker information

| | | | | | |
|----------------------------|--|---------------------------------------|-------------------------|-------------------------|-----------------------------------------------------------------|
| Worker last name | | First name | | Middle initial | Gender M <input type="checkbox"/> F <input type="checkbox"/> |
| Date of birth (yyyy-mm-dd) | | Home phone number (include area code) | | Social insurance number | |
| Address line 1 | | | Address line 2 | | |
| City | | Province/state | Country (if not Canada) | Postal code/zip | |

| | | |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| 1. What is the worker's occupation? | 2. Has the worker 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, was the worker (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"/> |
| | Casual <input type="checkbox"/> | Other (please specify) <input type="checkbox"/> |

Incident information

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------|
| 5. Date and time of incident (yyyy-mm-dd) | | 6. Period of exposure resulting in occupational disease (yyyy-mm-dd) | |
| a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> OR | | From To | |
| 7. Did worker report injury or exposure to employer? Yes <input type="checkbox"/> No <input type="checkbox"/> | 8. The injury or disease was first reported to employer on (yyyy-mm-dd) | | |
| 9. Name of person reported to | | | |
| (please check one) TO: First aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Other <input type="checkbox"/> (please specify) | | | |
| 10. Describe how the incident happened | | 11. Describe the injury in detail (what part of the body was injured) | |
| 12. Side of body injured Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable <input type="checkbox"/> | | | |
| 13. Describe the work incident location (address, city, province) and where incident occurred (e.g. shop floor, lunchroom, parking lot) | | | |
| 14. Did the injury(ies) or exposure result from a specific incident? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 15. Contributing factors — select AT LEAST ONE, and as many as applicable | | | |
| Lifting <input type="checkbox"/> | Overexertion <input type="checkbox"/> | Repetitive (activity repeated over and over again) <input type="checkbox"/> | Slip or trip <input type="checkbox"/> |
| Twist <input type="checkbox"/> | Fall <input type="checkbox"/> | Animal bite <input type="checkbox"/> | Assault <input type="checkbox"/> |
| | | Motor vehicle accident <input type="checkbox"/> | Unsure/other (please explain below) <input type="checkbox"/> |
| | | Struck <input type="checkbox"/> | |
| | | Crush <input type="checkbox"/> | |
| | | Sharp edge <input type="checkbox"/> | |
| | | Fire or explosion <input type="checkbox"/> | |
| | | Harmful substance in the work environment <input type="checkbox"/> | |





Employer's Report of Injury or Occupational Disease (continued)

| | | | |
|-------------------------|------------|-----------------------------------------|------------------------------------|
| Worker last name | First name | Middle initial | WorkSafeBC claim number (if known) |
| Social insurance number | | Personal health number from BC CareCard | |

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 16. Were there any witnesses? Yes <input type="checkbox"/> No <input type="checkbox"/> | 17. Did the incident occur in British Columbia? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 18. Were the worker's actions at time of injury for the purpose of your business? Yes <input type="checkbox"/> No <input type="checkbox"/> | 19. Did the incident occur on employer's premises or an authorized worksite? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 20. Did the incident happen during the worker's normal shift? Yes <input type="checkbox"/> No <input type="checkbox"/> | 21. Was the worker performing their regular duties at the time of the incident? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 22. Did the worker 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) |
| 23. Did the worker 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 address (if known) | |
| 24. Are you aware of any recent pain or disability in the area of the worker's reported injury? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 25. Do you have any objections to the claim being allowed? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please explain) | |

Wage information

| | | | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|-----|-----|-----|-----|-----|--|--|--|--|--|--|--|
| 26. Did the worker miss any time from work beyond the date of injury or exposure? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | | | |
| 27. Provide the base salary amount for this employment position at the time of injury \$ _____ Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 28. Does worker receive other amounts of compensation in addition to base salary ? Yes <input type="checkbox"/> No <input type="checkbox"/> Does worker receive vacation pay on every cheque? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, vacation pay _____% | 29. If worker is disabled from work, will you continue to pay: Base salary? Yes <input type="checkbox"/> No <input type="checkbox"/> Other amounts of compensation in addition to base salary ? Yes <input type="checkbox"/> No <input type="checkbox"/> Will worker receive vacation pay on every cheque? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, vacation pay _____% | | | | | | | | | | | | | | |
| Please select check boxes for any of the following amounts worker receives in addition to base salary AND provide the amount for each: Tips and gratuities <input type="checkbox"/> \$ _____ Room and board <input type="checkbox"/> \$ _____ Shift differential <input type="checkbox"/> \$ _____ Other <input type="checkbox"/> \$ _____ Overtime <input type="checkbox"/> \$ _____ | | | | | | | | | | | | | | | |
| Please select check boxes for any of the following amounts worker will continue to receive in addition to base salary AND provide the amount for each: Tips and gratuities <input type="checkbox"/> \$ _____ Room and board <input type="checkbox"/> \$ _____ Shift differential <input type="checkbox"/> \$ _____ Other <input type="checkbox"/> \$ _____ Overtime <input type="checkbox"/> \$ _____ | | | | | | | | | | | | | | | |
| 30. Provide the amount of gross earnings for the past 3 months or 12 weeks prior to the date of injury or exposure \$ _____ 3 months <input type="checkbox"/> 12 weeks <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 31. Does the worker have a fixed-shift rotation? Yes <input type="checkbox"/> No <input type="checkbox"/> 32. If no, please explain | | | | | | | | | | | | | | | |
| 33. If yes, show the normal work week by entering the paid hours | | | | | | | | | | | | | | | |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:14.28%;">Sun</td> <td style="width:14.28%;">Mon</td> <td style="width:14.28%;">Tue</td> <td style="width:14.28%;">Wed</td> <td style="width:14.28%;">Thu</td> <td style="width:14.28%;">Fri</td> <td style="width:14.28%;">Sat</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> | | Sun | Mon | Tue | Wed | Thu | Fri | Sat | | | | | | | |
| Sun | Mon | Tue | Wed | Thu | Fri | Sat | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 34. Did the worker continue to work past day of injury? Yes <input type="checkbox"/> No <input type="checkbox"/> 35. Last day worked (yyyy-mm-dd) | | | | | | | | | | | | | | | |
| 36. Number of hours scheduled to work on last day worked | | | | | | | | | | | | | | | |
| 37. Number of hours worked on last day | | | | | | | | | | | | | | | |
| 38. Number of hours paid by employer on last day worked | | | | | | | | | | | | | | | |

Return-to-work information

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 39. Has the worker returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 40. If YES: Date (yyyy-mm-dd) Since the return to work, have the worker's duties, hours of work, work schedule, and/or rate of pay changed? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 41. If NO: Do you have any modified or transitional duties available? Yes <input type="checkbox"/> No <input type="checkbox"/> Have the modified or transitional duties been offered to the worker? Yes <input type="checkbox"/> No <input type="checkbox"/> | 42. If yes, please describe modified or transitional duties |

Signature and report date

| | | |
|------------------------|--------------------|---------------------------------|
| 43. Employer signature | 44. Employer title | 45. Date of report (yyyy-mm-dd) |
|------------------------|--------------------|---------------------------------|

For assistance, please call our Claims Call Centre at 604 231-8888 or toll-free within Canada at 1 888 967-5377.
Please note: If you have concerns with this claim, please contact the officer handling the claim at the WorkSafeBC office to make known your objections or you may submit a letter detailing your specific concerns.
Impartial advice on WorkSafeBC claims – To ensure you have an opportunity to obtain impartial advice on WorkSafeBC claims matters, the BC legislature has provided impartial advisers. Employers' Advisers are available to provide independent advice or clarification on a WorkSafeBC claim related to your firm. For additional information on the Employers' Advisers, please refer to their web site at www.labour.gov.bc.ca/eaof/.

| | | | |
|-----------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|--------------------------------------------|
| Lower Mainland 604 713-0303 (Richmond) Toll free 1 800 925-2233 | Kelowna 250 717-2050 1 866 855-7575 | Prince George 250 565-4285 1 888 608-8882 | Victoria 250 952-4821 1 800 663-8783 |
|-----------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|--------------------------------------------|

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.

