WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

WCB INJURY REPORT

TO PROTECT THE PERSONAL PRIVACY OF THOSE INVOLVED, THIS DOCUMENT MUST NOT BE TRANSMITTED BY EMAIL. PLEASE SUBMIT BY FAX TO (902) 491-8001

This form is editable. Instructions:
1. Save the form. **2.** Type the information required.
3. Print. **4.** Sign. **5.** Fax to 902-491-8001.

EMPLOYER INFORMATION (Please TYPE required information.)

BUSINESS #: | | | | | | | | | NW | | | | | FIRM #: | | | | | | DIVISION #: | | | | | | |

COMPANY NAME: _____ CONTACT NAME: _____

ADDRESS: _____ CONTACT PHONE: ( ) _____ FAX: ( ) _____

PROVINCE: _____ POSTAL CODE: _____ EMAIL: _____

WORKERS INFORMATION (Please TYPE required information.)

NAME: _____ NS HEALTH CARD: | | | | | | | | | | |

OCCUPATION: _____ SOCIAL INSURANCE #: | | | | | | | | | |

ADDRESS: _____ DATE OF BIRTH: | | | | | | | | |
DATE (dd/mm/yyyy)

CITY/TOWN: _____

PROVINCE: _____ POSTAL CODE: _____ GENDER: ◯ MALE ◯ FEMALE

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____ CELL PHONE: ( ) _____

WCB USE ONLY:

FIRM# / BN

DIV #

CLIENT ID

CLAIM #

ISU

HALIFAX:
5668 South Street, PO Box 1150
Halifax, Nova Scotia B3J 2Y2
Tel: (902) 491-8999
Fax: (902) 491-8001
Toll Free: 1-800-870-3331

SYDNEY:
404 Charlotte Street, Suite 200
Sydney, Nova Scotia B1P 1E2
Tel: (902) 563-2444
Toll Free: 1-800-880-0003

DECLARATION AND CONSENT (Please TYPE required information.)

THE WORKERS' COMPENSATION ACT REQUIRES THAT BOTH THE EMPLOYER AND THE WORKER SIGN THIS REPORT. If the worker is not immediately available, the employer should sign and forward to the WCB without the worker's signature. It is unlawful to knowingly submit false or misleading information to the WCB.

☐ I declare that all the information provided by me is true and correct to the best of my knowledge.

OR

☐ I declare that I have reviewed the information provided by the worker, and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the worker.

_____ | | | | | | | | |
EMPLOYER'S SIGNATURE/TITLE DATE (dd/mm/yyyy)

( ) _____
PHONE

IT IS UNLAWFUL TO COLLECT FULL EARNINGS REPLACEMENT BENEFITS WHILE WORKING OR CAPABLE OF WORKING. YOU MUST ADVISE WCB OF ANY CHANGE IN YOUR EMPLOYMENT STATUS.

☐ I declare that all the information provided by me is true and correct to the best of my knowledge.

OR

☐ I declare that I have reviewed the information provided by the employer, and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the employer.

This will serve the Workers' Compensation Board as my consent to obtain and distribute any information from MSI/ Medavie Blue Cross, that the WCB determines is necessary to process this claim.

_____ | | | | | | | | |
WORKER'S SIGNATURE DATE (dd/mm/yyyy)

Notice: The WCB may obtain and share any information necessary to process this claim with appropriate health-care professionals and government agencies. Such information may include, but is not necessarily limited to, current and prior medical records, examinations, treatments and income information.

When an injury occurs, your first priority is to ensure your employee gets first aid and medical attention. YOU MUST REPORT ALL INJURIES REQUIRING MEDICAL ATTENTION OR WHERE THE WORKER WILL LOSE TIME FROM WORK. You must also investigate the incident right away to prevent it from happening again.

This form must be completed by both the employer and the injured worker and forwarded to the Workers' Compensation Board (WCB). Submit this form no more than FIVE BUSINESS DAYS after the injury was reported to you. Penalties can apply for late submissions.

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SOCIAL INSURANCE NUMBER

WCB Claim No.

WCB INJURY REPORT

INJURY INFORMATION (Please TYPE required information.)

To be completed by both the employer and the worker. If more space is needed, please attach additional pages, or use the space provided on page 3.

1. Please check one. The injury or illness occurred:

☐ From a specific incident.

DATE (dd/mm/yyyy) TIME ◯AM ◯PM

Please complete questions 2 - 7.

☐ Over a period of time.
Date symptoms first noticed: DATE (dd/mm/yyyy)

Please complete questions 2-12

2. What body part was injured?

☐ Left side ☐ Right side ☐ Upper body ☐ Lower body

3. How did the injury(ies)/illness(es) happen? List any and all weights, distances, movements and equipment involved and the conditions or activity occuring at the time of the incident. If relevant, list exposures to noise or chemical agents, and the duration of the exposure.

Where did the injury(ies) occur? CITY/TOWN

COUNTY PROVINCE

If a person/factor, other than the employer/coworkers contributed to the cause of injury/illness, please explain:

4. If medical attention was sought, please provide the name of the doctor OR medical facility where the worker was first seen. Also provide the date, phone number and location of the doctor OR medical facility.

Was medical attention sought? ◯YES ◯NO

NAME OF DOCTOR OR MEDICAL FACILITY

LOCATION

( ) PHONE DATE (dd/mm/yyyy)

5. Did the worker lose time because of this injury or illness? ◯YES ◯NO

If yes, give the date and time when time-loss started:

DATE (dd/mm/yyyy) TIME ◯ AM ◯ PM

Did the worker lose earnings because of this injury/illness? ◯YES ◯NO

If yes, give the date and time when earnings-loss started:

DATE (dd/mm/yyyy) TIME ◯ AM ◯ PM

Please complete page 3 if you answered yes to either of these questions.

6. Indicate if the worker is:
☐ proprietor ☐ partner ☐ active officer or director of the company

Indicate if the worker is a family member living in the household of any proprietor/partner/active officer or director of the company. ◯YES ◯NO

7. To whom at your place of employment was the injury or illness reported?

NAME

TITLE ( ) PHONE

Date reported: DATE (dd/mm/yyyy)

Please explain any delay in reporting:

OVER A PERIOD OF TIME SECTION

8. What are the worker's main job tasks?

9. Is the worker left or right hand dominant? ◯ LEFT ◯ RIGHT

10. How long has the worker been employed in this specific job/position?

If less than 90 days, in what job/position were they previously employed?

11. How much overtime did the worker perform in the 90-180 days before this injury or illness occurred?

12. Have there been any changes in the worker's responsibilities in the past 90-180 days? (e.g. changes in duties, changes in workload, a leave of absence.) Please explain.

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EARNINGS / EMPLOYMENT INFORMATION (Please TYPE required information.)

If you answered YES to either time loss or earnings loss in question 5, please complete this section.

The earnings information provided will normally be used to establish the benefit amount. We may request additional earnings information from both the employer and the worker to determine a more accurate benefit amount. Benefits provided by the Canada Pension Plan may affect the amount WCB pays.

13. Has the worker been employed with this company for the 12 months preceeding the earnings loss? ◯ YES ◯ NO

14. Indicate the worker's employment type:

A. ☐ Permanent ☐ Casual/Temporary ☐ Seasonal/Irregular

B. ☐ Sub-contractor ☐ Vehicle Owner/Operator ☐ Courier Service

☐ Logging/Chain Saw Operator ☐ Self-employed

☐ Other: _____

Note: if you check any box in B above, the worker must submit a detailed income and expense statement. If this information is not readily available, the WCB will estimate the worker's employment expenses.

15. If the worker is part-time, seasonal, or casual, please indicate the date the **original** employment began: ☐☐ ☐☐ ☐☐☐☐
DATE (dd/mm/yyyy)

16. A. Worker's normal gross earnings at the time of the injury: $_____

◯ per hour ◯ per day ◯ per week ◯ bi-weekly

◯ per month ◯ other (please specify): _____

Note: complete B only if you are unable to complete A, above. (Usually applies to seasonal, irregular or casual workers).

B. Gross earnings for the period of one year or less: $_____

From: (12 months or less prior) ☐☐ ☐☐ ☐☐☐☐

To: (Date before injury) ☐☐ ☐☐ ☐☐☐☐
DATE (dd/mm/yyyy)

17. Usual number of hours/days worked:

_____ ☐ Hours ☐ Days

☐ Per Day ☐ Per Week

☐ Other:

Show usual days of work:

☐ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S

If shift or casual worker, please attach the first three weeks of schedule after the earnings loss began. If the worker works on a fixed rotation schedule, please attach a sample of the rotation schedule.

18. Indicate the worker's tax deduction (TD) code: _____

19. Number of hours **scheduled** on day time/earnings loss began: _____

Number of hours **worked** on day time/earnings loss began: _____

Number of hours **paid** on day time/earnings loss began: _____

20. Did the worker return to work after the injury or onset of symptoms?

◯ YES ◯ NO

If yes, give the date and time:

☐☐ ☐☐ ☐☐☐☐ ☐☐:☐☐ ◯ AM ◯ PM
DATE (dd/mm/yyyy) TIME

Did the worker return to **regular** duties? ◯ YES ◯ NO

If yes, give the date and time:

☐☐ ☐☐ ☐☐☐☐ ☐☐:☐☐ ◯ AM ◯ PM
DATE (dd/mm/yyyy) TIME

21. Will you be making any payments to the worker while the worker is off work due to the injury or illness?

◯ YES ◯ NO

If yes, type of benefit paid: _____

How long will payments continue? _____

Please provide any additional injury/illness information that you feel is relevant: