Clear Form

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

Halifax Office
1-800-870-3331 toll free
902-491-8999 local
902-491-8001 fax

Sydney Office
1-800-880-0003 toll free
902-563-2444 local
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Service Provider Incident Form

WCB Claim #:
Health Card #:

WORKER INFORMATION

Worker's Last Name:	First Name:	Initial:	Date of Birth: dd mm yyyy
Date of Incident: dd mm yyyy	Date Reported to Clinic: dd mm yyyy	Reported to:	

HEALTH CARE PROVIDER INFORMATION

Provider Name:		ID#:
Completed by:	Date Reported: dd mm yyyy	Phone:

INCIDENT INFORMATION

Description of Incident [include exact location, what was being done and details of injury including body part]:

Reported Symptoms/Concerns (include new diagnosis if known):

Contributing Factors:

Initial Action(s) Taken:

Medical Attention Sought? Yes ☐ No ☐	If yes, name and type of provider:
Witness Name(s):	Phone Number(s):

IMPACT ON RTW PLAN

Did incident impact RTW? Yes ☐ No ☐	New RTW Date, if different: ☐ Transitional Duties: Start date: dd mm yyyy End Date: dd mm yyyy	☐ Pre-Injury Duties: Start: dd mm yyyy

Additional Information (specific changes to plan, different duties, etc):

RECOMMENDED TREATMENT PLAN (if modified due to incident)

Goals:	Methodology:	Recommended Time Frame
		From: dd mm yyyy To: dd mm yyyy
		From: dd mm yyyy To: dd mm yyyy

DECLARATION AND CONSENT (Worker and Service Provider initials and signatures required)

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

☐ Worker ☐ PT I declare that I have reviewed the information provided and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the other party (Worker/Service Provider).

Worker's Signature:	Date: dd mm yyyy	Service Provider Owner/Manager Signature:	Date: dd mm yyyy

Copied to WCB Claim file