

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.

		•	
BUSINESS #:	NW LLL		
ADDRESS:	CONTAC	TPHONE: ()	FAX: ()
PROVINCE:	POSTAL CODE:	EMAIL:	:
	WORKER'S INFORMATION (Plea	ase TYPE the require	d information.)
NAME:		NS HEALTH CARD:	
			E#:
ADDRESS:		_ DATE OF BIRTH:	DATE (LIV Co.)
CITY/TOWN:		_	DATE (dd/mm/yyyy)
PROVINCE:	POSTAL CODE:	SEX:	MALE ☐ FEMALE ☐
HOME PHONE: ()	WORK PHONE: ()	CELL PHONE: ()
			se TYPE the required information.)
Firm # / BN ———————————————————————————————————	While the WCB encourages employers and workers to fill out this form together, the worker may not always be available. WHEN THE WORKER IS NOT IMMEDIATELY AVAILABLE, THE EMPLOYER SHOULD SIGN THE REPORT AND SEND IT 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 comment and provided a copy to the worker.		
Client ID			
Claim #	EMPLOYER'S SIGNATURE		Date (dd/mm/yyyy)
ISU	TITLE		() PHONE
	IT IS UNLAWFUL TO COLLECT FUI WORKING. YOU MUST ADVISE WO		EMENT BENEFITS WHILE WORKING OR CAPABLE OF YOUR EMPLOYMENT STATUS.
HALIFAX: 200-137 Venture Run Dartmouth, NS B3B 0L9 Tel: (902) 491-8999 Fax: (902) 491-8001 Toll Free: 1-800-870-3331	 □ 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. 		
SYDNEY: 404 Charlotte Street, Suite 101 Sydney, Nova Scotia B1P 1E2 Tel: (902) 563-2444 Fax: (902) 563-0512 Toll Free: 1-800-880-0003	WORKER'S SIGNATURE Notice: The WCB may obtain and sh	are any information nece cies. Such information m	DATE (dd/mm/yyyy) essary to process this claim with appropriate health-care nay include, but is not necessarily limited to, current and

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.



HALIFAX:

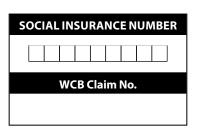
200-137 Venture Run Dartmouth, NS B3B 0L9 Tel: (902) 491-8999

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SYDNEY:

404 Charlotte Street, Suite 101 Sydney, Nova Scotia B1P 1E2 Tel: (902) 563-2444

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WCB INJURY REPORT

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. The injury or illness occurred (please check one): From a specific incident. DATE (dd/mm/yyyy) TIME Over a period of time. Date symptoms first noticed: DATE (dd/mm/yyyy) Injury Type: Psychological Injury Sprain/Strain that occurred over	5. Did the worker lose time because of this injury or illness?			
 ☐ Head Injury ☐ Crush and Bruise Injury ☐ Cuts and Puncture Injuries ☐ Back Injuries ☐ Broken Bones ☐ Other: ☐ Did the incident result in death? ☐ Yes ☐ A period of time ☐ Sprain/Strain ☐ Injuries as result of exposure to chemicals, allergic reaction, sustained loud noise, etc. ☐ Other: 	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?			
IF PSYCHOLOGICAL INJURY, COMPLETE SECTIONS 3–7 AND 13–21. ALL OTHERS, COMPLETE SECTIONS 2–21	NAME			
2. What part of the body was injured? ☐ Left Side ☐ Right Side ☐ Upper Body ☐ Lower Body	TITLE () PHONE RELATIONSHIP TO THE WORKER			
3. How did the injury(ies)/illness(es) happen? List any and all weights, distances, movements and equipment involved and the conditions or activity occurring at the time of the incident. If relevant, list exposures to noise or chemical agents, and the duration of the exposure. If the injury is due to work-related mental stress, describe the significant or cumulative work-related stressors, such as harassment and bullying, that occurred.	Date Reported: DATE (dd/mm/yyyy) Please explain any delay in reporting:			
narassment and bullying, that occurred.	OVER A PERIOD OF TIME SECTION			
Where did the injury(ies) occur? CITY/TOWN	8. What are the worker's main job tasks? 9. Is the worker left or right hand dominant? Left Right			
COUNTRY PROVINCE	10. How long has the worker been employed in this specific job?			
If a person/factor, other than the employer/coworkers contributed to the cause of injury/illness, please explain:	If less than 90 days, in what job/position were they previously employed?			
4. If health care services were sought, please provide the name of the medical practitioner or facility where the worker was first seen. Also provide the date, phone number and location of the medical practitioner or facility.	. 11. How much overtime did the worker perform in the 90-180 days before this injury or illness occurred?			
Were health care services sought?	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.			
LOCATION () PHONE DATE (dd/mm/yyyy)				



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SOCIAL INSURANCE NUMBER				
WCB Claim No.				

WCB INJURY REPORT

EARNINGS AND EMPLOYMENT INFORMATION (Please TYPE required information.) If you answered YES to either time loss or earnings loss in question 5, please complete this section.				
	nefit amount. We may request additional earnings information from both the lefits 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 preceding the earnings loss?	17. Usual number of hours/days worked:			
Please provide any additional injury/illness information that you feel is relevant:				