

1. Save the form. 2. Type the information required.
3. Print. 4. Sign. 5. Fax to 902-491-8001.

1/2026

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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. The injury or illness occurred (please check one):

☐ From a specific incident.

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☐ AM ☐ PM
DATE (dd/mm/yyyy) TIME

☐ Over a period of time.

Date symptoms first noticed:

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DATE (dd/mm/yyyy)

Injury Type:

- | | |
|---|---|
| <input type="checkbox"/> Psychological Injury | <input type="checkbox"/> Sprain/Strain that occurred over a period of time |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Sprain/Strain |
| <input type="checkbox"/> Crush and Bruise Injury | <input type="checkbox"/> Injuries as result of exposure to chemicals, allergic reaction, sustained loud noise, etc. |
| <input type="checkbox"/> Cuts and Puncture Injuries | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Back Injuries | |
| <input type="checkbox"/> Broken Bones | |

Did the incident result in death? ☐ Yes ☐ No

IF PSYCHOLOGICAL INJURY, COMPLETE SECTIONS 3-7 AND 13-21.
ALL OTHERS, COMPLETE SECTIONS 2-21

2. What part of the body 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 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.

Where did the injury(ies) occur? _____

CITY/TOWN

COUNTRY _____

PROVINCE _____

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

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.

Were health care services sought? ☐ Yes ☐ No

NAME OF MEDICAL PRACTITIONER OR FACILITY _____

LOCATION _____

()
PHONE _____

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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:

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☐ AM ☐ PM
DATE (dd/mm/yyyy) TIME

Did the worker lose earnings because of this injury/illness? ☐ Yes ☐ No

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

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☐ AM ☐ PM
DATE (dd/mm/yyyy) TIME

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 _____

RELATIONSHIP TO THE WORKER _____

Date Reported:

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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? _____

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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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.

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 preceding 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:

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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)

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To: (Date before injury)

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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:

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☐ AM ☐ PM
DATE (dd/mm/yyyy) TIME

Did the worker return to **regular** duties? ☐ Yes ☐ No

If yes, give the date and time:

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☐ 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: