

## 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'S INFORMATION (Please TYPE the required information.)**BUSINESS #:  NW 

COMPANY NAME: \_\_\_\_\_ REPORTED BY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CONTACT PHONE: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**WORKER'S INFORMATION (Please TYPE the required information.)**NAME: \_\_\_\_\_ NS HEALTH CARD:      OCCUPATION: \_\_\_\_\_ SOCIAL INSURANCE #:      ADDRESS: \_\_\_\_\_ DATE OF BIRTH:        
DATE (dd/mm/yyyy)

CITY/TOWN: \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_ SEX: MALE  FEMALE 

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_

**WCB USE ONLY:**

Firm # / BN

Div #

Client ID

Claim #

ISU

**HALIFAX:**

200-137 Venture Run  
Dartmouth, NS B3B 0L9  
Tel: (902) 491-8999  
Fax: (902) 491-8001  
Toll Free: 1-800-870-3331

**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

**DECLARATION AND CONSENT (Please TYPE the required information.)**

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.

EMPLOYER'S SIGNATURE

   

Date (dd/mm/yyyy)

TITLE

(\_\_\_\_\_)

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 **TWO BUSINESS DAYS** after becoming aware of the injury. Penalties can apply for late submissions.

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**SOCIAL INSURANCE NUMBER**

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**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. 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:

Psychological Injury  
 Head Injury  
 Crush and Bruise Injury  
 Cuts and Puncture Injuries  
 Back Injuries  
 Broken Bones

Sprain/Strain that occurred over a period of time  
 Sprain/Strain  
 Injuries as result of exposure to chemicals, allergic reaction, sustained loud noise, etc.  
 Other: \_\_\_\_\_

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?

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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 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.

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: