



WORKER'S REPORT of Injury or Occupational Disease C060

Seven Digit Claim #:

Worker Information

Past the day of injury: Have you been off work? Yes No Have your work duties been modified? Yes No

Form fields for Worker Information including Last Name, Former Name, First Name, Initial, Address, Apt #, Social Insurance #, City, Province, Postal Code, Health Care #, Daytime Phone, Evening Phone, Date of Birth, Sex, Occupation and Job Title, Self employed?, E-mail address, and Apprenticeship status.

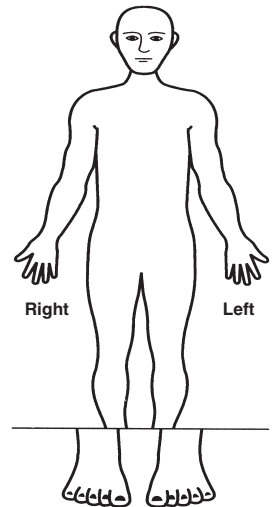
Employer Information

Form fields for Employer Information including Business Name or Government Department, Mailing Address, City, Province, Postal Code, and Phone.

Injury or Occupational Disease Information

Main injury information section with 10 numbered questions (1-10) covering date and time of injury, notification, location, work details, injury description, and medical treatment.

Circle part injured Please check: Front Back



Your Last Name: _____ First Name: _____ Initial: _____
 Social Insurance #: _____ Date of Birth: _____ (Year / Month / Day) Phone: _____

Time Lost / Return to Work Information PLEASE COMPLETE ALL THAT APPLY

11 a. Date and time you first missed work: _____ (Year / Month / Day) Time: _____ a.m. _____ p.m.
 b. Will/did your employer pay you while off work? No Yes, pre-accident wages Yes, but revised rate: \$ _____ per _____
 c. Is there any other work you can do until you are medically fit to return to your regular job? Yes No
 If yes, who can we call to discuss alternate work on your behalf? _____ Phone: _____
 d. If you have not returned to work give the expected return to work date: _____ (Year / Month / Day)
 e. If you have returned to work, indicate the date: _____ (Year / Month / Day) Time _____ a.m. _____ p.m. Regular work, or Modified work
 f. If back on modified work, are you: Being paid your pre-accident rate of pay? Yes No – provide rate: \$ _____ per _____
 Working pre-accident hours? Yes No – provide hours: _____ per _____

Type of Employment (Complete A or B or C)

12 **A** Permanent position employed 12 months of the year: Permanent full-time Permanent part-time
 or **B** Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs):
 Seasonal worker Temporary position Casual as needed Summer student Volunteer
 Had this injury not occurred, your last day of employment would have been: _____ (Year / Month / Day) Estimated or Actual
 Did you have any other earnings, or income from any other employers, during the last 12 months? Yes - Please attach copies of pay stubs and/or T4 slips
 or **C** Special employment circumstance:
 Contractor/sub contractor Vehicle owner/operator Welder owner/operator Commission Piece work Other/self-employed
 Do you incur expenses to perform the work (materials, tools, etc.)? Yes No Will you receive a T4? Yes No
Note: If you have checked any box in 12C please submit a detailed income and expense statement.

Wage Information Date you were hired: _____ (Year / Month / Day)

13 a. Your rate of pay at time of accident: \$ _____ Hourly Weekly Bi-weekly Semi-monthly Monthly Other
 b. Additional taxable benefits:
 Vacation Pay Included in rate of pay %: _____ OR Taken as time off with pay
 Stat Holiday Pay Included in rate of pay %: _____ OR Taken as time off with pay
 Shift Premium #1 Amount: \$ _____ → Paid per:
 Shift Premium #2 Amount: \$ _____ → Paid per:
 Regular Overtime Rate: \$ _____ → Number of hours: per Week Month Shift cycle
 Other Explain: _____ → Amount: per Week Month Shift cycle
 c. Do you have a second job? Yes No If yes – Employer's Name: _____ Phone: _____
 (Second employer may be contacted.)
 d. Did you miss time from this second job? Yes No If yes, please attach earning information and time missed details.

Hours of Work

14 a. Number of hours (not including overtime): _____ per Day Week Shift cycle Other
 b. Does the work schedule repeat? No Yes → Mark hours worked for one complete work schedule (use zero for days off)
 Average hours worked per week: _____

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day							
Hours per day							
Hours per day							

IMPORTANT
Circle day of injury.
See instructions
 c. Date shift cycle commenced _____ (Year / Month / Day)
 or if your schedule is more than 21 days, attach a copy of the schedule.



Your Last Name:	First Name:	Initial:
Social Insurance #:	Date of Birth: <small>(Year / Month / Day)</small>	Phone:

Declaration and Consent

I declare that the information in the 'Worker's Report of Injury or Occupational Disease' form will be true and correct.

I understand that:

- While I am receiving any benefits from WCB, it is my obligation to inform WCB immediately if I return to work of any kind, become capable of working or if there is any other change in my employment status. Work includes but is not limited to any activity in which labour or services are provided, whether or not payment of any kind is received.
- Criminal prosecution may result from any attempt on my part to collect benefits by providing false information, failing to provide information regarding my ability to work, or other fraudulent means.
- My employer may request a review or appeal of any decisions made on my claim and may therefore examine my claim file. My claim file may also be examined by anyone with a direct interest, as determined by WCB, or a person or company I have authorized to review my claim file. (To provide authorization, use the 'Worker's Information Release' form in this booklet).
- My social insurance number may be used for reporting to Canada Revenue Agency.
- WCB may collect information that it considers relevant to determine benefit entitlement, including information pre-dating my accident, from any source including physicians, other health care providers, employer(s) and vocational rehabilitation service providers. This information is collected to determine my entitlement to compensation under the *Workers' Compensation Act*.

WCB may use and disclose the information collected to determine entitlement, to provide services and benefits and, as required or authorized by law. This information may be used and disclosed pursuant to the *Workers' Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

(Year / Month / Day)

Date: Name (please print): _____

Signature: _____

Signing the above consent enables the Workers' Compensation Board to process your claim.

NOTE: The information required in the Worker's Report is collected under sections 33(a) and (c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of determining entitlement to compensation and for determining employers' premium rates. Questions may be directed to the Customer Contact Centre as noted on the front of this form and on the back of the Worker Handbook. The information provided to the Workers' Compensation Board is protected by the provisions of the *Freedom of Information and Protection of Privacy Act*.

This report form is part of a booklet of information intended to help workers with completing the necessary WCB forms and understanding the process. Keep the booklet for your reference.

