



# EMPLOYER'S REPORT OF INJURY OR OCCUPATIONAL EXPOSURE

As an employer, the *Workers Compensation Act* requires you to submit this report **within three days** of an injury to one of your workers, even if you disagree with the claim. By submitting your report promptly, you avoid penalties and delays in the adjudication of the claim. Please report using one of the following options:

- Online — The quickest and easiest option:** The online screen application customizes questions to the worker's injury. You can save your report and update it later with new information. Once submitted, you can follow the status of the claim online. Go to **WorkSafeBC.com** and select "Report an injury or illness."
- Fillable PDF form:** Type in your details online, print the form, and submit it by **FAX** or **MAIL**. Go to **WorkSafeBC.com** and select "Report an injury or illness."
- Paper form:** Clearly PRINT details, sign the form, and submit it by **FAX** or **MAIL**.

**FAX:** 604 233-9777 in Greater Vancouver or **toll-free** within BC at 1 888 922-8807  
**MAIL:** WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

WorkSafeBC claim number (if known)
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## Employer information

Employer's name (as registered with WorkSafeBC)		Type of business	
WorkSafeBC account number	Classification unit number	Operating location number	
Employer address line 1 (mailing)	Employer contact last name	First name	
Employer address line 2 (mailing)	Employer contact telephone (and area code)	Extension	Employer contact fax (and area code)
City	Province/state	Employer payroll contact last name	First name
Country (if not Canada)	Employer payroll contact telephone (and area code)	Extension	Employer payroll contact fax (and area code)

## Worker information

Worker last name	First name	Middle initial	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Date of birth (yyyy-mm-dd)	Home phone number (include area code)	Social insurance number	
Address line 1		Address line 2	
City	Province/state	Country (if not Canada)	Postal code/zip

1. What is the worker's occupation?	2. Has the worker been employed by this firm for less than 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	3. If yes, start date (yyyy-mm-dd)
4. At the time of injury, was the worker (check all that apply)		
Permanent <input type="checkbox"/>	Apprentice <input type="checkbox"/>	Self-employed <input type="checkbox"/>
Temporary <input type="checkbox"/>	Volunteer <input type="checkbox"/>	Principal/partner or relative of employer <input type="checkbox"/>
Full time <input type="checkbox"/>	Student <input type="checkbox"/>	Fisher <input type="checkbox"/>
Part time <input type="checkbox"/>	New entrant to workforce <input type="checkbox"/>	Hired on a contract basis <input type="checkbox"/>
	Casual <input type="checkbox"/>	Other (please specify) <input type="checkbox"/>

## Incident information

5. Date and time of incident (yyyy-mm-dd)		6. Period of exposure resulting in occupational disease (yyyy-mm-dd)	
		From To	
7. Did worker report injury or exposure to employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	8. If yes, date reported to employer (includes first aid) (yyyy-mm-dd)	9. Name of person reported to	
10. Describe how the incident happened		11. Describe the injury in detail (what part of the body was injured)	
		12. Side of body injured Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Not applicable <input type="checkbox"/>	
13. Describe the work incident location (address, city, province) and where incident occurred (e.g. shop floor, lunchroom, parking lot)			
14. Did the injury(ies) or exposure result from a specific incident? Yes <input type="checkbox"/> No <input type="checkbox"/>			
15. Contributing factors — select AT LEAST ONE, and as many as applicable			
Lifting <input type="checkbox"/>	Overexertion <input type="checkbox"/>	Repetitive (activity repeated over and over again) <input type="checkbox"/>	Slip or trip <input type="checkbox"/>
Twist <input type="checkbox"/>	Fall <input type="checkbox"/>	Animal bite <input type="checkbox"/>	Assault <input type="checkbox"/>
		Motor vehicle accident <input type="checkbox"/>	Unsure/other (please explain below) <input type="checkbox"/>
		Struck <input type="checkbox"/>	
		Crush <input type="checkbox"/>	
		Sharp edge <input type="checkbox"/>	
		Fire or explosion <input type="checkbox"/>	
		Harmful substance in the work environment <input type="checkbox"/>	





# Employer's Report of Injury or Occupational Exposure *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number <i>(if known)</i>
		Social insurance number	Personal health number from BC CareCard

	Yes	No	Please explain
16. Were there any witnesses?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, _____
17. Did the incident occur in British Columbia?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Were the worker's actions at time of injury for the purpose of your business?	<input type="checkbox"/>	<input type="checkbox"/>	If no, _____
19. Did the incident occur on employer's premises or an authorized worksite?	<input type="checkbox"/>	<input type="checkbox"/>	If no, _____
20. Did the incident happen during the worker's normal shift?	<input type="checkbox"/>	<input type="checkbox"/>	If no, _____
21. Was the worker performing their regular duties at the time of the incident?	<input type="checkbox"/>	<input type="checkbox"/>	If no, _____
22. Are you aware of any previous pain or disability in the area of the worker's reported injury?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, _____
23. Did the worker go to hospital, clinic, or visit a physician or qualified practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	Date (yyyy-mm-dd) _____
If yes, please provide: Provider name <i>(if known)</i> _____			
24. Did the worker receive first aid?	<input type="checkbox"/>	<input type="checkbox"/>	Date (yyyy-mm-dd) _____
If yes, please provide: First aid attendant name <i>(if known)</i> _____			
25. Do you have any objections to the claim being allowed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>(If yes, please explain)</i>

### Wage information

26. Did the worker miss any time from work beyond the date of injury or exposure?	Yes <input type="checkbox"/>	No <input type="checkbox"/>														
<b>If NO WORK WAS MISSED and NO CHANGE to duties/pay, proceed to bottom of page to sign, date, and submit this report. If WORK WAS MISSED or if duties/pay have been MODIFIED, please answer ALL questions on this form.</b>																
27. If work missed: Provide the base salary amount for this employment position at the time of injury	\$ _____															
	Hourly <input type="checkbox"/>	Weekly <input type="checkbox"/>														
	Bi-weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>														
	Yearly <input type="checkbox"/>															
28. Does worker receive other amounts of compensation in addition to base salary?																
Vacation pay <input type="checkbox"/> _____%	Shift differential <input type="checkbox"/> \$ _____	Overtime <input type="checkbox"/> \$ _____														
Does the worker receive vacation pay on every cheque?	Room and board <input type="checkbox"/> \$ _____	Other <input type="checkbox"/> \$ _____														
Yes <input type="checkbox"/> No <input type="checkbox"/>	Tips and gratuities <input type="checkbox"/> \$ _____															
29. Provide the amount of <b>gross</b> earnings for the past 3 months or 12 weeks prior to the date of injury or exposure	\$ _____															
	3 months <input type="checkbox"/>	12 weeks <input type="checkbox"/>														
30. Does the worker have a fixed-shift rotation?	31. If no, please explain															
Yes <input type="checkbox"/> No <input type="checkbox"/>																
32. If yes, show the normal work week by entering the paid hours	<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td>Sun</td> <td>Mon</td> <td>Tue</td> <td>Wed</td> <td>Thu</td> <td>Fri</td> <td>Sat</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		Sun	Mon	Tue	Wed	Thu	Fri	Sat							
Sun	Mon	Tue	Wed	Thu	Fri	Sat										
33. Did the worker continue to work past day of injury?	34. Last day worked (yyyy-mm-dd)	35. Is worker continuing to receive their full salary?														
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>														
36. Number of hours scheduled to work on last day worked	37. Number of hours worked on last day	38. Number of hours paid by employer on last day worked														

### Return-to-work information

39. Has the worker returned to work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
40. If YES: Date (yyyy-mm-dd)	Since the return to work, have the worker's duties, hours of work, work schedule, and/or rate of pay changed?	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
41. If NO: Do you have any modified or transitional duties available?	42. If yes, please describe modified or transitional duties	
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Have the modified or transitional duties been offered to the worker?	▶	
Yes <input type="checkbox"/> No <input type="checkbox"/>		

### Signature and report date

43. Employer signature	44. Employer title	45. Date of report (yyyy-mm-dd)
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**For personal assistance**, please call our Claims Call Centre at 604 231-8888 or toll-free within BC at 1 888 967-5377.

The BC Legislature provides impartial advisers on all workers' compensation matters. For more information, call the Employers' Advisers Office at 604 713-0303, or toll-free within BC and Alberta at 1 800 925-2233. To locate the Employers' Advisers office nearest you, visit [www.labour.gov.bc.ca/eao/](http://www.labour.gov.bc.ca/eao/)

