



401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, Telephone: (867) 667-5645: Toll free: 1-800-661-0443, Fax: (867) 667-8740, Website: www.wcb.yk.ca

TELL US ABOUT YOUR WORKER

Worker's last name _____		Worker's first name _____		Initial _____	<input type="checkbox"/> Male
					<input type="checkbox"/> Female
Worker's mailing address _____ _____ _____			Home telephone # ()		
			Work telephone # ()		
			E-mail address _____		
Date of birth (d/m/y) _____	During your busy periods, do you regularly employ 20 or more workers? <input type="checkbox"/> Yes <input type="checkbox"/> No		Social insurance # _____		
Employer's name and address (include government department if applicable) _____ _____ _____			Worker's occupation _____		
			Name of supervisor _____		
			Employer's telephone # ()		
			Employer's cell # ()		

TELL US ABOUT THE WORKER'S INJURY/ILLNESS

Date of injury/illness. If injury occurred over time, indicate date worker first reported problems to the employer (d/m/y) _____		Time _____		<input type="checkbox"/> AM
				<input type="checkbox"/> PM
What equipment was being used? _____		Part of body injured (indicate left or right) _____		
What happened? _____ _____				
Do you have any reason to believe this claim should be denied? <input type="checkbox"/> Yes <input type="checkbox"/> No		When was the injury/illness reported to supervisor? _____		
Has the worker sent in a Worker's Report of Injury/Illness <input type="checkbox"/> Yes <input type="checkbox"/> No		City, town or place of injury/illness _____		
Was first aid given at the work site? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, please attach a copy of the first aid report		Did the injury/illness happen on the employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No
				Was the worker doing work for employer when the injury occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did the worker seek medical attention beyond the work site? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did the worker miss work after the date of injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, this is a Time Loss Claim. Please complete the box below.

TIME LOSS CLAIM

Has the worker returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, when (d/m/y)? _____		If No, have you created a Return-to-Work Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please provide the worker's gross income for the 2 full pay periods immediately prior to the injury/illness					
From (date) _____		to (date) _____		\$ _____	
and (date) _____		to (date) _____		\$ _____	
OR: Who would we contact for this information? _____					
				*If this is a time loss claim, you may be contacted for further information Telephone _____	

This report must be submitted to the Yukon Workers' Compensation Health and Safety Board ASAP. Employers will be fined if this report is not received within 3 days of when you become aware of the injury. It can be faxed, mailed or dropped off at our office.

Major injuries (including fractures, loss of consciousness, etc.) must be reported to the Yukon Workers' Compensation Health and Safety Board **IMMEDIATELY**. Call (867) 667-5450 or 1-800-661-0443.

ABOUT YOUR INFORMATION

I declare that the above information is true and correct to the best of my knowledge, and I am authorized to sign this report on behalf of the employer.

Signature _____ Date (d/m/y) _____

Print Name _____ Telephone Number _____

This information is being collected under the authority of the *Workers' Compensation Act* for the purpose of determining eligibility for benefits. For further information, contact (867) 667-5645 or 1-800-661-0443.