Workers' Safety and Compensation Board Yukon

EMPLOYER'S REPORT OF INJURY/ILLNESS

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	☐ Male ☐ 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? ☐ Yes ☐ No

Social insurance #

Worker's occupation

Employer's name and address *(include government department if applicable)*

_____

_____

_____

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 _____ ☐ AM ☐ 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? ☐ Yes ☐ No

When was the injury/illness reported to supervisor?

Has the worker sent in a Worker's Report of Injury/Illness ☐ Yes ☐ No

City, town or place of injury/illness

Was first aid given at the work site? ☐ Yes ☐ No *If Yes, please attach a copy of the first aid report*

Did the injury/illness happen on the employer's premises? ☐ Yes ☐ No

Was the worker doing work for employer when the injury occurred? ☐ Yes ☐ No

Did the worker seek medical attention beyond the work site? ☐ Yes ☐ No

Did the worker miss work after the date of injury/illness? ☐ Yes ☐ No *If Yes, this is a Time Loss Claim. Please complete the box below.*

TIME LOSS CLAIM

Has the worker returned to work? ☐ Yes ☐ No

If Yes, when *(d/m/y)*?

If No, have you created a Return-to-Work Plan? ☐ Yes ☐ 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 Workers' Safety and Compensation 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 Workers' Safety and Compensation 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' Safety and Compensation Act* for the purpose of determining eligibility for benefits. For further information, contact (867) 667-5645 or 1-800-661-0443.