Workers' Safety and Compensation Board Yukon

APPLICATION FOR COMPENSATION BENEFITS

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 YOU

Worker's last name	Worker's first name	Initial	☐ Male ☐ Female

Worker's mailing address	Home telephone # ( )
	Work telephone # ( )
	Cell number # ( )
	E-mail address
Date of birth *(d/m/y)*	Social insurance #
Employer's name and address *(include government department if applicable)*	Worker's occupation
	Name of supervisor
	Supervisor's telephone # ( )
	Cell number # ( )

TELL US ABOUT YOUR INJURY/ILLNESS

In your own words, what happened?

Part of body injured *(indicate left or right)*	Have you hurt this part of your body before? ☐ Yes ☐ No
Date of injury/ illness *(d/m/y)*	If your injury/illness occurred over time, when did you first experience symptoms?
Who did you report the injury/illness to?	When did you report the injury/illness *(d/m/y)*?
What were your hours of work on the day of injury/illness? *(from/to)*	What equipment was being used?

Was first aid given at the work site? ☐ Yes ☐ No	Were you doing work for your employer when the injury/illness occurred? ☐ Yes ☐ No	Did the injury/illness happen on the employer's premises? ☐ Yes ☐ No

Did you seek medical attention beyond first aid at the work site? ☐ Yes ☐ No	If so, where?
When?	Who treated you?

Did you miss work after the date of injury/illness? ☐ Yes ☐ No	Have you returned to work? ☐ Yes ☐ No	If Yes, when *(d/m/y)*?

If you have not already done so, you need to report your injury/illness to your employer right away. You can give them a copy of this form.

ABOUT YOUR INFORMATION

I declare that the information provided is true and correct. I consent to the release from any source including the Canada Revenue Agency to the Workers' Safety and Compensation Board (WSCB) of any medical or employment information relevant to my claim. I consent to WSCB disclosing to healthcare providers, hospitals, physicians, my employers, other workers' compensation boards, Canada Revenue Agency and any other relevant third parties, all relevant information necessary to administer my claim in accordance with the law.

I acknowledge that WSCB may collect information it considers relevant to my claim to determine benefit entitlement and that my social insurance number may be used for reporting to Canada Revenue Agency and collecting information from Canada Revenue Agency for the purpose of determining benefit entitlement in accordance with the law.

Signature _____ Date *(d/m/y)* _____

This information is being collected under the authority of the *Workers' Safety and Compensation Act* for the purpose of determining eligibility for benefits. WSCB may obtain and disclose information from this claim, to the employer for the purpose of appeal, or may disclose such information to others in accordance with the law, including the *Workers' Safety and Compensation Act*.