Workers' Safety and Compensation Board Yukon

F-0036 - 02.00 - Employer report of fatality

PRINTED: 23-11-2026

This information is being collected for the purposes of administering and enforcing the Workers' Safety and Compensation Act and is collected under the authority of that Act and the Access to Information and Protection of Privacy Act. If you have any questions about the collection of this information, please contact the Privacy Officer at WSCB at the above listed address or at (867)667-5645 or 1-800-661-0443.

This report must be submitted to 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.

Please complete this form as thoroughly as possible.

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.

Worker Information

*Worker's first name

*Worker's gender

Male

Female

Other

Worker's middle initial

*Worker's last name

*Worker's mailing address (character limit: 570)

*Worker's occupation

What is the worker's job? This field is required.

What is the worker's home address? This field is required.

Name of supervisor

Who supervised the worker?

Employer Information

During your busy periods, do you regularly employ 20 or more workers?

Yes

No

*Employer's name

*Employer's mailing address (character limit: 570)

What is the name of your employer? This field is required.

What is the full mailing address of your employer? This field is required.

Employer's phone number (ex: (999) 999-9999)

Employer's cell number (ex: (999) 999-9999)

What is your company's main telephone number? This field is required.

Is there a cell number we can reach you at?

Department (for Government of Yukon only)

If you work for the Government of Yukon, in what department?

*Are you a partner, owner or proprietor in this business?

Yes

No

Partner

Owner

Proprietor

Work-related injury information

*Date of injury/illness (DD/MM/YYYY)

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If the injury occurred over time, indicate the date that the worker first reported problems to you. This field is required.

Did the injury/illness happen on the employer's premises?

No

Yes

What equipment was being used?

*Was the worker doing work for the employer when the injury occurred?

Yes

No

City, town or place of injury/illness

Was first aid given at the work site?

No

This field is required.

Yes

Where did the worker get hurt?

Describe, based on the information you have, what happened to cause the incident that lead to the fatality? (character limit: 1140)

Time loss claim

Contact for payroll information

Phone (ex: (999) 999-9999)

Who handles payroll in your organization?

Submission verification

*Your name

In place of a signature, please verify your identity. This field is required.

*Your email address (ex: you@wcb.yk.ca)

We'll send an acknowledgement of this submission to your email address. This field is required.

Your phone number (ex: (999) 999-9999)

For any follow-up, we'll need your phone number.

Declaration

By submitting this form, I declare this information is true and correct.