

PRINTED: 11-10-2026

This information is being collected for the purpose of administering and enforcing the Workers' Safety and Compensation Act in compliance with the Access to Information and Protection of Privacy Act. If you have any questions about the collection of this information, please contact the board's privacy officer at 401 Strickland St., Whitehorse, YT, Y1A 5N8 or call 867-667-5645 or 1-800-661-0443.

If you are entitled and receiving wage loss benefits, you need to have your wage loss compensation reviewed every year. Please fill out and submit the Wage Loss Verification of Information form to the board. Make sure your health care provider fills out and submits the wage loss annual medical report, which you can find on the website or by using the link provided after you submit the Wage Loss Verification of Information form.

You need to submit your wage loss forms by July 2nd. If you can't do this, contact your case manager before that date.

Worker Information

Claim Number

* First Name

Middle Name

* Last Name

* Street Number

As shown on valid government-issued ID

Apartment Number/Unit Number

* Street Name

* City

* Province/Territory

* Country

* Postal Code

Email (ex: you@wcb.yk.ca)

* Primary Phone Number (ex: (999) 999-9999)

* Is the physical address the same as mailing address?

Yes

No

Mailing Address (character limit: 570)

Only fill out if mailing address is different from address you provided above

Self-Report of Functional Abilities

* Please select your injury type

Physical

Psychological

PRINTED: 11-10-2026

- * In the last 12 months, have your workplace injury symptoms
- increased
 - decreased
 - stay the same

Please explain (character limit: 1140)

What are you doing to manage your workplace injury?

- exercise
- following up with your health care provider
- medication
- other
- none

Please explain (character limit: 570)

If you have a claim accepted for a physical injury, has there been a change in the last year in your ability to participate in activities involving

- walking
- sitting,
- climbing stairs/ladder
- lifting
- bending, twisting and kneeling
- other

Please explain the changes (character limit: 1140)

PRINTED: 11-10-2026

If you have a claim accepted for a psychological injury, has there been any changes in the last year, in the following

concentration

participation in social activities

memory

complex thinking

self-care

other

Please explain the changes (character limit: 1140)

Income Information

* Have you worked in the last 12 months?

Yes

No

* Has your employment/occupation changed in the last year?

Yes

No

Please explain (character limit: 1140)

* Do you expect your employment earnings to change in the current year?

Yes

No

PRINTED: 11-10-2026

Please explain (character limit: 1140)

Earnings

* Have you filed your taxes for last year?

Yes

No

* If you have not filed your taxes, do you intend on filing your taxes for last year?

Yes

No

* Have you received any salary, wages, commissions, tips, remuneration for overtime, piece work and contract work, bonuses and allowances, the cash equivalent of board and lodging, store certificates, credits, directors fees, indemnities and allowances paid to members of the Legislative Assembly, or any substitute for money, as earnings during the last year?

Yes

No

* Please explain (character limit: 570)

* Have you received any benefits from any other workers' compensation boards in Canada or any other jurisdiction?

Yes

No

* Please identify the type of benefit, the name of the workers' compensation board and the amount of the benefit you received (character limit: 570)

Please provide any further information you feel may be relevant to your annual review. Thank you (character limit: 570)

Do you need additional space to provide more information

Yes

No

PRINTED: 11-10-2026

Signature, consent and declaration

I acknowledge that electronic communication has inherent security risks, as do all forms of communication. Notwithstanding the inherent risks of electronic communication, I consent to the use of electronic methods to transmit and receive information, including confidential and personal information between the board and myself. This consent will remain in effect until written notice to revoke this authorization has been received by the board.

By checking this box I declare that the information provided is true and correct. I consent to the release from any third party to the Workers' Safety and Compensation Board (board) of any medical, employment or other information relevant to my claim. I consent to the board disclosing to health care providers, hospitals, physicians, my employers, other workers' compensation boards and any other relevant third parties, all relevant information necessary to administer my claim in accordance with the law.

My name is/Signature

Date (DD/MM/YYYY)

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