

PRINTED: 14-10-2026

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 867-667-5642 or 1-800-661-0443.

Worker Information

* First Name

As shown on valid government-issued ID

* Last Name

As shown on valid government-issued ID

Also known as

* Street Number

Apartment Number/Unit Number

* Street Name

* City

* Province/Territory

* Postal Code

* Country

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

Work Phone Number (ex: (999) 999-9999)

* Date of Birth (DD/MM/YYYY)

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Claim Number

Part of body affected (check all that apply)

Left Fingers

Left Hand

Left Wrist

Left Forearm

Left Elbow

Left Shoulder

Left Neck

Left Upper Back

Left Lower Back

Left Hip

Left Knee

Left Foot

Left Other

Text input

Right Fingers

Right Hand

Right Wrist

Right Forearm

Right Elbow

Right Shoulder

Right Neck

Right Upper Back

Right Lower Back

Right Hip

Right Knee

Right Foot

Right Other

Date of injury (DD/MM/YYYY)

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Employer

Heath care provider information

Clinic Name

Therapist Name

Street Number

Apartment Number/Unit Number

* Street Name

* City

* Province/Territory

* Country

Postal Code

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

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

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

Fax Number (ex: (999) 999-9999)

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Reassessment Date (DD/MM/YYYY)

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Treatment Summary

Treatment dates since last report

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Has the worker missed any appointments

Yes

No

Total number of missed appointments

Overall functional progress

Improving

No change

Declining

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Objective Findings

* Observation findings (character limit: 570)

* ROM and Biomechanical Analysis (character limit: 570)

* Strength (character limit: 570)

Neurological (character limit: 570)

Special test and results

Test name

Result

Checkbox

none

Worker's current occupation

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List the worker's five most critical job demands
Critical job demand

Current ability

Job match

Is the Job Demands Analysis for this occupation needed?

Yes

No

Treatment plan

Treatment goals

Recommended treatment (Methodology)

Frequency and expected duration of treatment
of visits/week

Duration

Recommended or prescribed equipment or supplies.

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Return to work

Based on current functional abilities, can regular duties be performed?

Yes

No

What can they do? (character limit: 570)

☐ Are there barriers to recovery or return to work?

Yes

No

Select possible barriers, if applicable.

Hesitancy to return to work

Not job attached or lack of appropriate modified work

Reported employee/employer issues

Pain/impairment barriers beyond expectation for injury

High perceived disability

Fear of movement of activity

Injured worker appears anxious or depressed

Severe injuries with likely long term or permanent work restrictions

Other health concerns affecting recovery. Explain:

Other (i.e., non-compensable conditions). Explain:

Text input

Has a Functional Abilities Form (FAF) been given to the worker?

Yes

No

Explain

Additional comments (character limit: 570)

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Section Header

Signature, consent and declaration

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Checkbox

By checking this box I declare that the information provided is true and correct. I consent to the release from any third party to 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

My email is (ex: you@wcb.yk.ca)