Workers' Safety and Compensation Board Yukon

Application for Compensation Benefits - Standard Claim

PRINTED: 07-11-2026

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.

Complete the Application for Compensation Benefits form only if you want to apply for loss of earnings and/or medical benefits in the Yukon. You must submit an Application for Compensation Benefits within 12 months of the date of your injury.

To help us process your application as quickly as possible, please complete this form as thoroughly as you can.

Please allow 30 to 40 minutes to complete this form

Worker Information

*First Name (As shown on valid government-issued ID)

Middle Name

*Last Name (As shown on valid government-issued ID)

Also Known As

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

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

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

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

Mailing Address (character limit: 570)

*Street Number

Apartment Number/Unit Number

*Street Name

*City

*Province/Territory

*Country

*Postal Code

*Is the physical address the same as mailing address?

Yes

No

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

*Gender

Male

Female

Other

*Do you require an interpreter or translation services?

Yes

No

For which language

*Date of Birth (DD/MM/YYYY)

/ /

Employer Information

*Business Legal Name

What is the name of the business on your paycheque?

Trade Name or Government Department

*Street Number

*Street Name

*City

*Province/Territory

*Postal Code

*Country

*Employer Contact Name

Provide the name of the person you want us to contact to discuss your claim and return-to-work options

*Employer Contact Title

Supervisor

Manager

HR

Health and Safety Rep

Business Owner

Other

*Employer Contact Phone Number (ex: (999) 999-9999)

*Employer Contact Email Address (ex: you@wcb.yk.ca)

*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

Work-Related Injury Information

For compensation to be payable, you must report your work-related injury to your employer.

PRINTED: 07-11-2026

*Date of work-related injury (DD/MM/YYYY)

/ /

*Time of work-related injury (HH:MM)

AM PM

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

Yes

No

*Have your reported this work related injury to your employer?

Yes

No

First name of person at your place of work you reported your work-related injury to.

Last name of person at your place of work you reported your work-related injury to.

Contact number for the person you reported your injury to. (ex: (999) 999-9999)

*Were you doing work for your employer when you got injured?

Yes

No

*Did your work-related injury occur on your employer's premises?

Yes

No

If no, please explain

*Did your work-related injury happen in the Yukon?

Yes

No

*What was your job at time of the work-related injury?

What is your job title, what do you do?

Proprietor

Partner

Owner

*What happened to cause your work-related injury? (character limit: 570)

*What part of your body was injured?

*Has this part of your body been injured before?

Yes

No

*What equipment were you using?

Selecting "Yes" does not exclude you from compensation

*What were your hours of work on the day you were injured? (HH:MM)

AM PM

What time did you start work?

AM PM

What time did you end work?

Please select where in Canada the work-related injury happened

If the work-related injury did not happen in Canada, where did it happen?

Tell us where the work-related injury happened outside of Canada

*Did you receive medical attention?

Yes

No

Name of clinic/hospital/doctor's office (character limit: 570)

If you received medical attention outside of the Yukon, please provide the name, city and province of that medical office

*Date you received medical attention (DD/MM/YYYY)

/ /

*Name of person who provided medical attention

*Was this a motor vehicle accident?

Yes

No

*Is your injury a psychological injury?

Yes

Did accident involve a train, plane or automobile?

No

*Please check one. Your work-related injury occurred

Over a period of time (e.g. tennis elbow from excessive use of arm)

On a specific day (e.g. broke wrist from a fall)

Occupational Injury Information

Only complete this section if you answered that your work-related injury occurred over a period of time.

We may need to arrange a worksite risk assessment to gather specific information about your job duties, such as how often you perform tasks and what forces are involved.

When did you first notice symptoms? (DD/MM/YYYY)

/ /

Date you were provided a diagnosis for your work-related injury? (DD/MM/YYYY)

/ /

Date you first missed work due to your work-related injury? (DD/MM/YYYY)

/ /

Please provide us with the name of any other clinic/hospital/doctors where you received treatment for this work-related injury? (character limit: 570)

A clinic/hospital/doctor includes: chiropractor, physiotherapist, nurse practitioner, psychologist, medical doctor

About your work-related injury

Only complete this section if you answered that your work-related injury occurred over a period of time.

Are you right-handed or left-handed?

- Right
- Left

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
- 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

Symptoms (check all that apply):

- Aching
- Burning
- Tingling
- Stiffness
- Other
- Numbness
- Pain
- Weakness

Do any of the following apply to you?

- Prior claims for same injury (including other compensation boards)
- Prior fractures or injuries to the same part of body
- Inflammatory disorder (such as arthritis)
- Family history of this condition
- Overweight
- Smoker
- Pregnancy

What makes your symptoms improve? (character limit: 570)

What makes your symptoms worse? (character limit: 570)

Do you have symptoms when you are not working?

Yes

No

Describe the symptoms you have when you are not working (character limit: 570)

List your 5 main job duties starting with those you do the most often (character limit: 570)

Has anything about your job changed?

Yes

No

Is there anything specific about your job or job duties that you think might be causing your work-related injury? (character limit: 570)

Explain what has changed (character limit: 570)

Certain tools you use, how you hold them, awkward or painful movements, etc.

Describe any hobbies you participate in outside of work? (character limit: 570)

Describe any physical activities you participate in outside of work? (character limit: 570)

Gaming, quilting, woodworking, hunting, etc.

Team sports, running, swimming, etc.

How much time do you spend on a home computer for personal use each week?

Earnings Information

We will use the information you provide about your earnings to calculate loss of earnings benefit . We will verify the wage information you provide with your employer.

*How long have you worked in this job?

*Please describe your current employment status

Seasonal

Full-time

Part-time

Piecework

Retired

*Did you miss time from work after the day of your work-related injury?

Yes

No

*Social Insurance Number

Needs to be 9 digits long

*What date did you start missing work? (DD/MM/YYYY)

/ /

PRINTED: 07-11-2026

*Is your employer continuing to pay you?

Yes

No

Unknown

*Do you have another job or other sources of employment income?

Yes

No

Additional employer information (character limit: 570)

List any other places you worked at the time of your injury

*Have you returned to work?

Yes - regular duties

Yes - modified duties

No

*When did you return to work? (DD/MM/YYYY)

/ /

Signature, consent and declaration

Email communication

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.

Declaration

By submitting this form, 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. I understand 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.