

Workers Compensation Board of PEI

 The Employer's Report may be submitted electronically with a WCB Online Services account. Visit [www.wcb.pe.ca](http://www.wcb.pe.ca)

Help your workers recover at work – Did you know that modified or alternate work can help an injured worker recover and can lower claim costs? To find out how, contact WCB Claims and Compensation.

**ALL INFORMATION IN SECTIONS 1 THROUGH 8 MUST BE COMPLETED FULLY**

<b>1. WORKER INFORMATION</b>			<input type="checkbox"/> <b>LOST TIME</b>	<input type="checkbox"/> <b>NO LOST TIME</b>	<input type="checkbox"/> <b>UNKNOWN</b>									
Last Name:		First Name:		Initials:										
Address:				City:										
Province:	Postal Code:	Home Telephone:		Date of Birth: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td>M</td><td>D</td><td>Y</td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table>		M	D	Y						
M	D	Y												
Job Title:		Employee #: <small>(if applicable)</small>	Date of Hire: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td>M</td><td>D</td><td>Y</td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table>			M	D	Y						
M	D	Y												
<b>2. EMPLOYER INFORMATION</b>														
Employer Firm Name:			Company Telephone:											
<b>WCB Firm Number (Mandatory Field):</b>			WCB Operation Number:											
Address:			Is the worker a partner/director in this business? <input type="checkbox"/> Y <input type="checkbox"/> N											
City:	Postal Code:	Province:	Does your firm have 20 or more workers? <input type="checkbox"/> Y <input type="checkbox"/> N											
Contact Name and Telephone:														
<b>3. INJURY OR OCCUPATIONAL DISEASE INFORMATION</b> COMPLETE EITHER <b>a</b> OR <b>b</b> OR <b>c</b>														
<b>a)</b> Please provide date and time of injury or specific incident.														
Date: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td>M</td><td>D</td><td>Y</td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table>		M	D	Y							Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.			
M	D	Y												
<b>b)</b> <input type="checkbox"/> The injury developed over a period of time.			<b>c)</b> <input type="checkbox"/> The injury is a recurrence of a prior injury.											
<b>4. REPORT TO EMPLOYER</b>														
Was the injury reported to the employer? <input type="checkbox"/> Y <input type="checkbox"/> N														
If yes, please provide the following: <b>To Whom:</b> _____ <b>Job Title:</b> _____														
Date: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td>M</td><td>D</td><td>Y</td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table>			M	D	Y							Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
M	D	Y												
Did the worker seek medical treatment? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown														
<b>5. LOCATION OF ACCIDENT</b>														
Did the injury occur in PEI? <input type="checkbox"/> Y <input type="checkbox"/> N			Did the injury occur on the employer's premises? <input type="checkbox"/> Y <input type="checkbox"/> N											
If no, where did it happen? _____														
<b>6. WITNESSES</b>														
Were there witnesses? <input type="checkbox"/> Y <input type="checkbox"/> N		Name: _____		Telephone: _____										
		Name: _____		Telephone: _____										
<b>7. PREVIOUS PAIN OR INJURY</b>														
Do you know of any previous pain or injury in the area of the worker's present injury? <input type="checkbox"/> Y <input type="checkbox"/> N														
If yes, please explain: _____														
<b>8. PART OF BODY</b>			<b>9. ACCIDENT DESCRIPTION</b>											
Head	Neck	Shoulder	<b>a)</b> Describe fully what happened: (If necessary, use a separate sheet)											
Forearm	Wrist	Upper back												
Low back	Hip/thigh	Knee												
Ankle/Foot	Hearing Loss													
Other														
<b>Side</b>			<b>b)</b> Do you have any issues or concerns? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please explain: _____											
Left		Right												

Please complete the other side

Submit Promptly

**COMPLETE SECTIONS 10 THROUGH 14 ONLY IF THE WORKER HAS MISSED TIME FROM WORK**

**10. TYPE OF EMPLOYMENT**

- a)  Full Time     Part Time     Other    Please Specify: \_\_\_\_\_  
 b)  Permanent     Seasonal     Temporary     Other    Please Specify: \_\_\_\_\_

Had the injury not occurred, what would be the worker's last day of work? 

M	D	Y					

- c) Is the worker employed as:  Contractor     Independent Operator     Apprentice     Not Applicable

**11. WAGE INFORMATION COMPLETE EITHER a or b**

- a) (i) Worker's Rate of Pay: \$ \_\_\_\_\_ (ii) Vacation Pay: % \_\_\_\_\_ (iii) Regular Overtime: \$ \_\_\_\_\_  
 Hourly     Monthly     Taken as paid time off     Hourly     Other  
 Weekly     Other     Included in regular wages     Weekly     N/A  
 Bi-Weekly     Other     Bi-Weekly

b) Gross Earnings:  Last 12 Months \$ \_\_\_\_\_ From: 

M	D	Y			

 To: 

M	D	Y			

  
OR Gross Earnings:  Last Tax Year \$ \_\_\_\_\_ Year: \_\_\_\_\_

**12. HOURS OF WORK COMPLETE EITHER a or b**

- a) Usual hours worked per day: \_\_\_\_\_ Usual number of days worked per week: \_\_\_\_\_  
 b) Average hours per week for shift workers: \_\_\_\_\_

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Wk 1 - Hours per day							
Wk 2 - Hours per day							
Wk 3 - Hours per day							

**Circle day of injury**

Does the work schedule repeat?  Y  N

Contact name for payroll information: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**13. LOST TIME / RETURN TO WORK INFORMATION**

Date worker first missed work: 

M	D	Y			

**SIN:** \_\_\_\_\_

Has the worker returned to work?  Y  N    If yes, please provide the date: 

M	D	Y			

Has the worker continued to receive regular pay?  Y  N

**14. RETURN TO WORK PLANNING**

Do you have a Return to Work program?  Y  N    Can you accommodate an easeback?  Y  N

Are modified/alternative duties available?  Y  N

Contact Name for Return to Work Planning: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**PLEASE NOTE:**

If you have concerns with this claim, please contact the Workers Compensation Board of PEI to discuss your concerns or you may submit a letter detailing your concerns. An Employer Advisor is available to provide advice and/or clarification on a WCB claim related to your firm. The Employer Advisor operates independently of the Workers Compensation Board and can be reached at 902-368-6132.

Your opinion is important to us. To improve services, the WCB may contract an independent survey company to survey a sample of employers. The WCB does not know which employers will be contacted. If you are contacted, we encourage you to participate. The research company does not share your personal responses with the WCB.

**Declaration:** I certify that the information given on this form is true. I agree to notify the Workers Compensation Board of PEI immediately of any change in circumstances affecting this claim, including any return to work. I understand that the Workers Compensation Act requires employers to submit a report within three days of notification or awareness of an injury or occupational disease requiring treatment or an absence from work. I am aware that penalties may be levied for late filing.

**Note:** Where applicable, the employer information on this form is collected under the authority of subsection 59(3) of the Workers Compensation Act and will be used for the purpose of identifying the accident employer and for monitoring workplace safety.

Name of person completing this form (print): \_\_\_\_\_

Job Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Are there extra pages added? YES  NO  If yes, how many?

The information on this form is collected under the authority of subsection 59(3) of the Workers Compensation Act and section 31 of the Freedom of Information and Protection of Privacy Act for the purposes of administering the compensation claims and monitoring workplace safety. If you have any questions about this collection of information, please contact WCB FOIPP Coordinator, Workers Compensation Board of PEI, 14 Weymouth Street, P.O. Box 757, Charlottetown, PE C1A 7L7, (902) 368-5680 or toll free at 1-800-237-5049.

**Print, complete and submit this form by mail, fax or in person to: 14 Weymouth Street, P.O. Box 757, Charlottetown, PE C1A 7L7**

**Do not email sensitive information.**

**Fax: 902-368-5696 Tel: 902-368-5680 or 1-800-237-5049**