Clear Form

Safety Matters @Work
Workers Compensation Board of PEI
wcb.pe.ca

WORKER'S REPORT

Email To: workerservices@wcb.pe.ca
Mail To: PO Box 757, Charlottetown, PE C1A 7L7
Drop Off: 14 Weymouth Street, Charlottetown, PE
Phone: 902-368-5680
Fax: 902-368-5696
Toll Free: 1-800-237-5049

Please complete the noise-induced hearing loss or repetitive strain injury forms if you are filing a claim for these types of injuries.

Worker Information

Please Print

First Name:	Last Name:		
Mailing Address:			
City:	Province:	Postal Code:	Country:
Provincial Health (PHN) #:		Date of Birth:	
Home Telephone:	Mobile Telephone:	Email:	

Employment Information

Job Title:		
Current Employer:	Dept. Name:	Supervisor's Name:
Address:	City:	
Province:	Postal Code:	Telephone:

Injury/Illness Information

Date of Injury or Illness:

Type: ◯ Physical Injury ◯ Psychological Condition ◯ Occupational Disease ◯ Fatality ◯ Other, specify:
Were your symptoms caused by: ◯ One incident : ◯ Developed over a period of time

Fully describe what caused your injury/illness:

Did you report the injury/illness to your employer: ◯ No ◯ Yes, when?:

Who was the injury/illness reported to?: Job Title: Telephone:

Were there witnesses? ◯ No ◯ Yes: Witness Name: Job Title:

What area(s) of your body did you injured/affected?

☐ Head			
☐ Neck			
☐ Shoulder:	◯ Left	◯ Right	◯ Both
☐ Back:	◯ Upper	◯ Middle	◯ Lower
☐ Forearm:	◯ Left	◯ Right	◯ Both
☐ Hand / wrist:	◯ Left	◯ Right	◯ Both
☐ Hip / thigh:	◯ Left	◯ Right	◯ Both
☐ Knee:	◯ Left	◯ Right	◯ Both
☐ Ankle / foot:	◯ Left	◯ Right	◯ Both

☐ Sudden Hearing Loss:
☐ Psychological injury, please describe:

☐ Other, specify:

SUBMIT TO THE WORKERS COMPENSATION BOARD WITHIN SIX MONTHS.
PLEASE DO NOT LEAVE THE ORIGINAL FORM WITH YOUR EMPLOYER.

Did the incident occur on the employer's premises? ◯ No ◯ Yes

Which county did the incident occur in? ◯ Prince ◯ Queens ◯ Kings ◯ Out-of-Province

Has a health care provider diagnosed you with a condition/injury? Describe:

Medical Information

Did you receive medical treatment? ◯ No ◯ Yes (please list below)

Clinic name or location	Health Care Provider's name	Treatment date	Treatment time	Description of treatment provided

List any medications you are currently taking directly relating to this condition/injury:

Section A - Occupational Disease Exposure Claims Only

When did you first notice your symptoms?

Employer when exposure was first experienced:

Job Title when exposure occurred:

Is there other employment that may have contributed to the disease? ◯ No ◯ Yes

Contributing Employer Name	Telephone (if known)	Years Worked

Type of Employment

Date Hired

Type of Employment

◯ Permanent Full Time ◯ Permanent Part Time ◯ Seasonal Work ◯ Owner/operator
◯ Casual ◯ Sub-Contract ◯ Summer Student ◯ Vehicle owner/operator
◯ Piece Work ◯ Self-Employed ◯ Other, specify:

Hours of Work

Does work schedule repeat? ◯ Yes, Days worked: ☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI ☐ SAT
Start of shift: ◯ a.m. ◯ p.m. End of Shift: ◯ a.m. ◯ p.m.

◯ No, describe the work schedule:

Hours of work per day: Per Week: Per Rotation:

With this employer, how many weeks per year would this job last?

How many weeks did you work in the previous year?

At the time of incident, did you have any other job?
◯ No ◯ Yes, other employer name: Telephone: Type of work:

Time Loss Information

Did you miss time from work as a result of your injury?

◯ No ◯ Yes: First missed work on: Number of days of work missed:

Have you returned to work?

◯ No ◯ Yes, date: Type of duties: ◯ Regular ◯ Modified

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Earnings Information (only complete if you have lost wages):

Social Insurance Number
Regular weekly rate of pay (*before deductions*): $ Hourly rate of pay: $

Did you have any earnings or income from other employers during the last 12 months? ◯ No ◯ Yes

Have you received Employment Insurance (EI) benefits in the last 12 months? ◯ No ◯ Yes

Banking Information

Do you want to add direct deposit information to your file?

◯ No

◯ Yes, provide: Bank Institution Number: _ _ _ Transit Number: _ _ _ _ _ Account Number: _____

DECLARATION - I authorize the WCB to deposit payments the worker is entitled to receive from them into the bank account specified on this form. I understand I must notify the WCB if the bank account information changes or is closed.

Comments:

Declarations **Please read carefully. Keep a copy of this form for your reference.**

- I solemnly declare that I will notify my employer and my health care providers that I am filing a claim for Workers Compensation; that I will immediately notify the WCB of PEI of any monies received for work done by me and of any changes in my ability to return to employment.
- I hereby consent to the release of information to my employer concerning my functional abilities and limitations. I understand and agree it may be used to assist me to return to employment safely.
- I understand that this will authorize the WCB to obtain or review information from any source whatsoever pertaining to [my/the worker's] situation, including records of physicians, qualified practitioners or hospitals, a copy of records pertaining to examinations, treatment, history, and employment.
- I will notify WCB of any application for or monies received from Long-Term Disability, Canada Pension Disability or from any other potential source of financial benefit as a result of this injury/accident.
- I understand that it is illegal to provide false or misleading information to WCB, its employees or service providers concerning a WCB claim.
- I make this solemn declaration as if it had the same force and effect as if made under oath.

NOTE: To improve its services, the WCB may contract an independent survey company to survey a sample of workers. The WCB does not know which workers will be contacted. If you are contacted, you can decide whether or not you want to take part. The research company does not share your personal responses with the WCB.

_____ _____
Completed by (Name) Date Completed

The information on this form is collected under the authority of section 6 (12) of the *Workers Compensation Act* and section 31 (a) and (c) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administering the compensation claims, determining employer assessment rates 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, PO Box 757, Charlottetown, PE C1A 7L7, 902-368-5680 or toll free at 1-800-237-5049.

THE *WORKERS COMPENSATION ACT* PROVIDES AUTHORITY TO REFER WORKERS AND/OR THEIR FILES TO MEDICAL OR REHABILITATION PERSONNEL.

ARE THERE EXTRA PAGES ADDED? ◯ NO ◯ YES, HOW MANY:

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Email: workerservices@wcb.pe.ca Fax: 902-368-5696 Tel: 902-368-5680 or 1-800-237-5049

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