WCB ACCIDENT REPORT

WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

This form must be completed by both the employer and the injured worker and forwarded to the Workers' Compensation Board (WCB) within **FIVE BUSINESS DAYS** of the accident or illness being reported to the employer. Failure to do so could result in penalties being imposed. If, due to the seriousness of the injury, the worker is not able to sign this form, please forward the Accident Report unsigned by the worker. **PLEASE PRINT CLEARLY**. This report is also available as a PDF (Portable Document Format) file which can be downloaded from the WCB website at www.wcb.ns.ca.

HALIFAX:
5668 South Street
PO Box 1150
Halifax, Nova Scotia
B3J 2Y2
Tel: (902) 491-8999
Toll Free: 1-800-870-3331
Fax: (902) 491-8001

SYDNEY:
404 Charlotte Street, Suite 200
Sydney, Nova Scotia
B1P 1E2
Tel: (902) 563-2444
Toll Free: 1-800-880-0003
Fax: (902) 563-0512

EMPLOYER INFORMATION

COMPANY NAME _____ BUSINESS # (OR FIRM NUMBER) _____

STREET _____ CITY/TOWN _____ CONTACT NAME _____

PROVINCE _____ POSTAL CODE _____ CONTACT PHONE _____

PHONE _____ FAX _____ EMAIL _____

TRADE NAME (IF DIFFERENT THAN COMPANY NAME) _____

WORKER INFORMATION

NAME _____ OCCUPATION _____

STREET _____ CITY/TOWN _____ NS HEALTH CARD # _____

PROVINCE _____ POSTAL CODE _____ SOCIAL INSURANCE # (PLEASE COMPLETE ON ALL PAGES) _____

MAILING ADDRESS (IF DIFFERENT THAN ABOVE) _____ DATE OF BIRTH (D/M/Y) _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____ GENDER: ☐ MALE ☐ FEMALE

WCB USE ONLY:

FIRM # / BN _____

DIV. # _____

CLIENT ID _____

CLAIM # _____

ISU _____

DECLARATION AND CONSENT

THE WORKERS' COMPENSATION ACT REQUIRES THAT BOTH THE EMPLOYER AND THE WORKER SIGN THIS REPORT. If the worker is not immediately available, the employer should sign and forward to the WCB without the worker's signature. It is unlawful to knowingly submit false or misleading information to the WCB.

EMPLOYER:

_____ I declare that all the information provided by me is true and correct to the best of my knowledge.

OR

_____ I declare that I have reviewed the information provided by the worker, and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the worker.

EMPLOYER'S SIGNATURE _____ TITLE _____

PHONE _____ DATE (D/M/Y) _____

IT IS UNLAWFUL TO COLLECT FULL EARNINGS REPLACEMENT BENEFITS WHILE WORKING OR CAPABLE OF WORKING. YOU MUST ADVISE WCB OF ANY CHANGE IN YOUR EMPLOYMENT STATUS.

WORKER:

_____ I declare that all the information provided by me is true and correct to the best of my knowledge.

OR

_____ I declare that I have reviewed the information provided by the employer, and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the employer.

This will serve the Workers' Compensation Board as my consent to obtain and distribute any information from MSI / Maritime Medical Care Inc., that the WCB determines is necessary to process this claim.

WORKER'S SIGNATURE _____ DATE (D/M/Y) _____

Notice: The WCB may obtain and share any information necessary to process this claim with appropriate health-care professionals and government agencies. Such information may include, but is not necessarily limited to, current and prior medical records, examinations, treatments and income information.

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MUST BE COMPLETED ON EACH PAGE

SOCIAL INSURANCE NUMBER

WCB Claim No.

WCB ACCIDENT REPORT

ACCIDENT INFORMATION

To be completed by both the employer and the worker. If more space is needed, please attach additional pages, or use the space provided on page 3.

1. Please **check one**. The injury or illness occurred:

☐ From a specific accident

_____ (DATE (D/M/Y)), _____ : _____ (TIME) ☐ AM ☐ PM

Please complete questions 2-7.

☐ Over a period of time. Date symptoms first noticed: _____ (DATE (D/M/Y))

Please complete questions 2-12.

2. What body part was injured? _____

☐ Left side ☐ Right side ☐ Upper body ☐ Lower body

3. **How** did the injury(ies) / illness(es) happen? List any and all weights, distances, movements and equipment involved and the conditions or activity occurring at the time of the incident. If relevant, list exposures to noise or chemical agents, and the duration of the exposure.

_____
CITY/TOWN/PROVINCE WHERE INCIDENT OCCURRED

Did any person or factor other than the employer or coworkers contribute to the cause of the injury or illness? ☐ YES ☐ NO

If person, please provide name: _____

If factor, please explain: _____

4. If medical attention was sought, please provide the name of the doctor **OR** medical facility where the worker was first seen. Also provide the date, phone number and location of the doctor **OR** medical facility.

_____
NAME OF DOCTOR OR MEDICAL FACILITY

_____
DATE (D/M/Y) PHONE LOCATION

5. Did the worker lose **time** because of this injury or illness? ☐ YES ☐ NO
If yes, give the date and time when time-loss started:

_____ (DATE (D/M/Y)), _____ : _____ (TIME) ☐ AM ☐ PM

Did the worker lose **earnings** because of this injury or illness? ☐ YES ☐ NO
If yes, give the date and time when earnings-loss started:

_____ (DATE (D/M/Y)), _____ : _____ (TIME) ☐ AM ☐ PM

Please complete page 3 if you answered yes to either of these questions.

6. Indicate if the worker is:

☐ a proprietor ☐ a partner ☐ an active officer or director of the company

Indicate if the worker is a family member living in the household of any proprietor / partner / active officer or director of the company.

☐ YES ☐ NO

7. To whom at your place of employment was the injury or illness reported?

_____
NAME

_____
TITLE PHONE

Date reported: _____ Please explain any delay in reporting:

IF THE INJURY OR ILLNESS OCCURRED OVER A PERIOD OF TIME, PLEASE COMPLETE QUESTIONS 8-12. USE EXTRA PAGES IF NECESSARY.

8. What are the worker's main job tasks?

9. Is the worker left or right hand dominant? ☐ Left ☐ Right

10. How long has the worker been employed in this specific job / position?

If less than 90 days, in what job / position were they previously employed?

11. How much overtime did the worker perform in the 90-180 days before this injury or illness occurred?

12. Have there been any changes in the worker's responsibilities in the past 90-180 days? (eg. changes in duties, changes in workload, a leave of absence). Please explain.

YOU MAY FAX/SUBMIT A JOB DESCRIPTION WITH THIS REPORT.

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SOCIAL INSURANCE NUMBER

WCB Claim No.

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EARNINGS / EMPLOYMENT INFORMATION

If you answered YES to either time loss **or** earnings loss in question 5, please complete this section.

The earnings information provided will normally be used to establish the benefit amount. We may request additional earnings information from both the employer and the worker to determine a more accurate benefit amount. Benefits provided by the Canada Pension Plan may affect the amount WCB pays.

13. Has the worker been employed with this company for the 12 months preceding the earnings loss? ☐ YES ☐ NO

14. Indicate the worker's employment type:

A. ☐ Permanent ☐ Casual / Temporary ☐ Seasonal / Irregular

B. ☐ Sub-contractor ☐ Vehicle Owner / Operator ☐ Courier Service

☐ Logging / Chain Saw Operator ☐ Self-Employed

☐ Other: _____

Note: If you check any box in B above, the worker must submit a detailed income and expense statement. If this information is not readily available, the WCB will estimate the worker's employment expenses.

15. If the worker is part-time, seasonal or casual, please indicate the date the **original** employment began. _____
DATE (D/M/Y)

16. A. Worker's **normal** gross earnings at the time of the injury: $ _____

☐ per hour ☐ per day ☐ per week ☐ bi-weekly
☐ per month ☐ other (please specify) _____

Note: complete B only if you are unable to complete A, above. (Usually applies to seasonal, irregular or casual workers).

B. Gross earnings for the period of one year or less: $ _____

From: _____ **to:** _____
12 MONTHS OR LESS PRIOR (D/M/Y) DATE BEFORE INJURY (D/M/Y)

17. Usual number of hours/days worked:

Hours per day _____ Days per week _____ Other _____

Show usual days of work: S___ M___ T___ W___ T___ F___ S___

If shift or casual worker, please attach the first three weeks of schedule after the earnings loss began. If the worker works on a fixed rotation schedule, please attach a sample of the rotation schedule.

18. Indicate the worker's tax deduction (TD) code: _____

19. Number of hours **scheduled** on day time/earnings loss began: _____

Number of hours **worked** on day time/earnings loss began: _____

Number of hours **paid** on day time/earnings loss began: _____

20. Did the worker return to work after the injury or onset of symptoms?

☐ YES ☐ NO

If yes, give the date and time:

_____ , _____ : _____ ☐ AM ☐ PM
DATE (D/M/Y) TIME

Did the worker return to **regular** duties? ☐ YES ☐ NO

If yes, give the date and time:

_____ , _____ : _____ ☐ AM ☐ PM
DATE (D/M/Y) TIME

21. Will you be making any payments to the worker while the worker is off work due to the injury or illness? ☐ YES ☐ NO

If yes, type of benefit paid: _____

How long will payments continue: _____

Use this space if necessary to explain any answers.