WSCC Workers' Safety & Compensation Commission | ᐃᖅᑲᓇᐃᔭᖅᑎᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪ ᓇᓪᓕᐅᒃᑯᒫᓂᒃ ᖃᐅᔨᓴᖅᑎᑦ

WSCC CLAIM: WORKER'S REPORT OF INJURY

If there is a question that does not apply, please indicate by writing 'N/A'.

A – Worker Information

1. First Name	2. Last Name	
3. Mailing Address	4. Community	5. Postal Code
6. Residential Address (if different than above)	7. Date of Birth YY MM DD	8. Male ☐ Female ☐

9. Telephone (Include Area Code)	Cell	Fax	Email Address

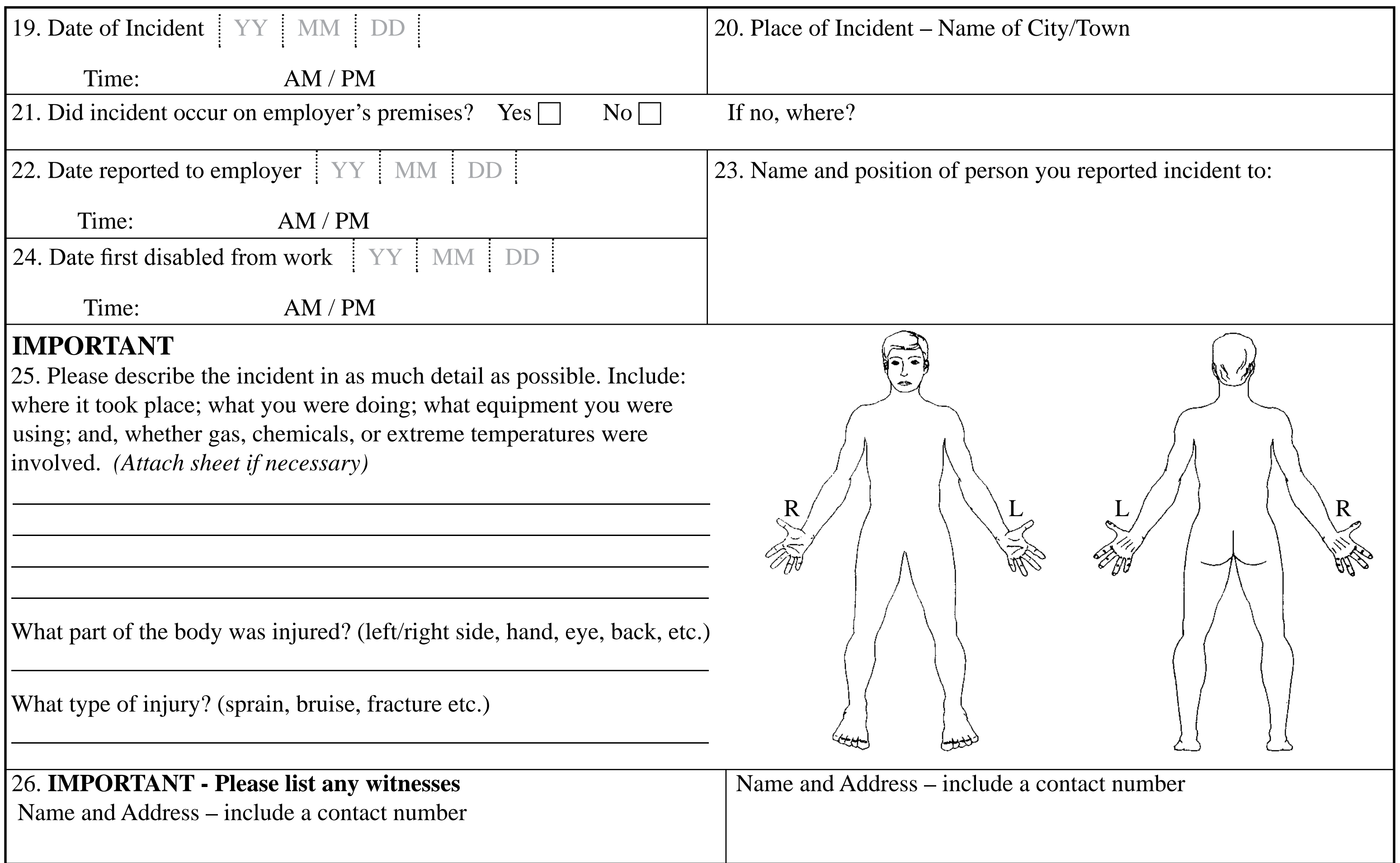
10. Social Insurance Number	11. Single ☐ Married ☐ Common-Law ☐ Widowed ☐ Divorced ☐

12. Number of Dependants	13. Job Title	14. Preferred Language ☐ English ☐ French ☐ Inuktitut ☐ Other

B – Employer Information

15. Employer Name	16. Address
17. Supervisor's Name	18. Telephone ( )

C – Incident Details



19. Date of Incident YY MM DD
Time: AM / PM

20. Place of Incident – Name of City/Town

21. Did incident occur on employer's premises? Yes ☐ No ☐ If no, where?

22. Date reported to employer YY MM DD
Time: AM / PM

23. Name and position of person you reported incident to:

24. Date first disabled from work YY MM DD
Time: AM / PM

IMPORTANT
25. Please describe the incident in as much detail as possible. Include: where it took place; what you were doing; what equipment you were using; and, whether gas, chemicals, or extreme temperatures were involved. *(Attach sheet if necessary)*

What part of the body was injured? (left/right side, hand, eye, back, etc.)

What type of injury? (sprain, bruise, fracture etc.)

26. **IMPORTANT - Please list any witnesses**
Name and Address – include a contact number

Name and Address – include a contact number

27. Have you been offered light duties? Yes ☐ No ☐	When? YY MM DD
28. Have you returned to work? Yes ☐ No ☐ If yes, ☐ Light Duties ☐ Regular Duties	When? YY MM DD
29. Name of Attendant if first aid was provided? Where?	When? YY MM DD
30. What Hospital / Health Care Centre did you go to?	When? YY MM DD
31. Name of attending Health Care Professional	

D. Past Injuries

32. Have you ever had an injury or disability to the same body part? (i.e. left foot, right hand)? Yes ☐ No ☐ When? YY MM DD

33. Have you had previous claims with this Commission, or any other Workers' Compensation Board?
If yes, provide dates and nature of injury.

PLEASE PROCEED TO SECTION "E" AND "F" ON THE 2ND PAGE. →

Worker's Full Name:

E – Employment Category

34. Worker's Type of Employment A) **Permanent**	B) **Non - Permanent**
Type of Permanent Employment - ☐ Term (*Over 1 year*) ☐ Full / Part time Permanent ☐ Apprentice ☐ Relief ☐ Other	***Type of Non-Permanent Employment -*** ☐ Term (*Under 1 year*) ☐ Seasonal ☐ Summer Student ☐ Casual ☐ Apprentice
35. Is the job subject to seasonal layoffs? Yes ☐ No ☐	36. Is the job subject to lack of work layoffs? Yes ☐ No ☐
37. First day of hire YY MM DD	

F – Schedule Information *(Please complete all questions that apply)*

38. Number of days on ______ Number of days off ______	39. Hours per Shift / Day _____	40. Hours per Rotation _____

41. Please circle days on for one full rotation:

M T W T F S S M T W T F S S M T W T F S S M T W T F S S

42. Date rotation started YY MM DD Date rotation ends YY MM DD

If NO WORK WAS MISSED and NO CHANGE to duties or pay, proceed to bottom of page and sign, date, and submit this report.
If WORK WAS MISSED or if duties or pay have been MODIFIED, please answer ALL questions on this form.

G – Wage Information *(Please complete all questions)*

43. What is your hourly rate of pay? ________ / hr What is your annual gross earnings? ____________________

If you are paid other than hourly or on salary please attach an explanation

44. Do you receive any other benefits? Yes ☐ No ☐ **If yes, explain in detail with amounts or averages:**
(eg: Vacation pay, Northern Allowance, Bonus)

45. Do you regularly work or get paid for overtime? Yes ☐ No ☐

46. Provide an estimate of regular overtime hours ________ / day week month (*Please circle*)

47. What is your overtime rate? ________ / hr

48. Are you being paid for lost time? Yes ☐ No ☐

49. Do you have a second job? Yes ☐ No ☐ If yes, have you missed time from this job due to your injury? Yes ☐ No ☐
(If you have more than one other employer please list all employers and their contact information)

Name of second employer: ______________________ Contact name and phone: ______________________

WORKER'S CONSENT

I hereby claim compensation for work-related injuries or disease.

Information Sharing- I understand that the above information about me will be used by the WSCC for the sole purpose of conducting an investigation into this claim. I also understand that the WSCC will need to gather more information about my work incident and medical and work history to administer my claim. For that specific purpose only, some personal information may have to be disclosed to employers, medical personnel and other relevant third parties.
I authorize the WSCC to provide and gather such information from all necessary sources, including hospital and doctors' records, and employer records.

Information Accuracy- I understand that incomplete information from me may delay my claim, and that untrue information from me is unlawful.
I declare the information above is true and accurate. I understand it may be a criminal offence to make a false claim, or to work and earn income while receiving workers' compensation without telling the WSCC.

Signature: ______________________ Date: ______________

Witness: ______________________ Date: ______________

For more information on our Legislation and Policies, please visit our Website
www.wscc.nt.ca • www.wscc.nu.ca

If you would like assistance filling in this form, or more information, please contact one of our offices listed below

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677
or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407• Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501
www.wscc.nt.ca or **www.wscc.nu.ca**

Ce formulaire est disponible on francais
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