YUKON WORKERS' COMPENSATION HEALTH AND SAFETY BOARD
COMMISSION DE LA SANTÉ ET DE LA SÉCURITÉ AU TRAVAIL DU YUKON

WORKER'S REPORT OF INJURY/ILLNESS

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, **Telephone:** (867) 667-5645: **Toll free:** 1-800-661-0443, **Fax:** (867) 456-6125, **Website:** www.wcb.yk.ca

TELL US ABOUT YOU

Worker's last name	Worker's first name	Initial	☐ Male ☐ Female

Worker's mailing address _____	Home telephone # ( )
	Work telephone # ( )
	Cell number # ( )
	E-mail address
Date of birth *(d/m/y)*	Social insurance #
Employer's name and address *(include government department if applicable)*	Worker's occupation
	Name of supervisor
	Supervisor's telephone # ( )
	Cell number # ( )

TELL US ABOUT YOUR INJURY/ILLNESS

In your own words, what happened? _____

Part of body injured *(indicate left or right)*	Have you hurt this part of your body before? ☐ Yes ☐ No
Date of injury/ illness *(d/m/y)*	If your injury/illness occurred over time, when did you first experience symptoms?
Who did you report the injury/illness to?	When did you report the injury/illness *(d/m/y)*?
What were your hours of work on the day of injury/illness? *(from/to)*	What equipment was being used?

Was first aid given at the work site? ☐ Yes ☐ No	Were you doing work for your employer when the injury/illness occurred? ☐ Yes ☐ No	Did the injury/illness happen on the employer's premises? ☐ Yes ☐ No
Did you seek medical attention beyond first aid at the work site? ☐ Yes ☐ No	If so, where?	
When?	Who treated you?	
Did you miss work after the date of injury/illness? ☐ Yes ☐ No	Have you returned to work? ☐ Yes ☐ No	If Yes, when *(d/m/y)*?

If you have not already done so, you need to report your injury/illness to your employer right away. You can give them a copy of this form.

ABOUT YOUR INFORMATION

I declare that the above information is true and correct, and I am filing a claim under the *Workers' Compensation Act*. I authorize the release from any source to the Yukon Workers' Compensation Health and Safety Board of medical and/or employment information relevant to my claim.

Signature _____ Date *(d/m/y)* _____

This information is being collected under the authority of the *Workers' Compensation Act* for the purpose of determining eligibility for benefits. YWCHSB may obtain and disclose information from this claim, to the employer for the purpose of appeal, or may disclose such information to others in accordance with the law, including the *Workers' Compensation Act*.

For further information regarding completing this form, contact (867) 667-5645 or 1-800-661-0443.