



# WCB ACCIDENT REPORT

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](http://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

### WCB USE ONLY:

FIRM # / BN
DIV #
CLIENT ID
CLAIM #
ISU

### 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: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

### 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.

<b>EMPLOYER:</b>	<input type="checkbox"/> I declare that all the information provided by me is true and correct to the best of my knowledge.
	<b>OR</b>
<input type="checkbox"/> 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.**

<b>WORKER:</b>	<input type="checkbox"/> I declare that all the information provided by me is true and correct to the best of my knowledge.
	<b>OR</b>
<input type="checkbox"/> 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.

# 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

\_\_\_\_\_, \_\_\_\_\_ : \_\_\_\_\_  AM  PM  
 DATE (D/M/Y) TIME

**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:

\_\_\_\_\_, \_\_\_\_\_ : \_\_\_\_\_  AM  PM  
 DATE (D/M/Y) TIME

Did the worker lose **earnings** because of this injury or illness?  YES  NO

If yes, give the date and time when earnings-loss started:

\_\_\_\_\_, \_\_\_\_\_ : \_\_\_\_\_  AM  PM  
 DATE (D/M/Y) TIME

**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.

# WCB ACCIDENT REPORT

## 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.