



EMPLOYER REPORT of Injury C040

Seven Digit Claim # (if available):

Claim Type

1 Time Lost Modified Work Fatality Complete entire report if claim type is one of the above

No Time Lost (Notice of non-disabling injury/illness) Complete first page only

Worker Details

Last Name: First Name: Initial: Mailing Address: Apt# Social Insurance #: City: Province: Postal Code: Personal Health #: Phone Number: Date of Birth: Gender: Occupation: Job description: Date hired: Does the worker have WCB personal coverage with this business? Is the worker a partner or director in this business? Is the worker an apprentice? If yes, date the worker would have obtained journeyman status:

Employer Details

Business Name or Government Department: WCB Account Number: Industry: Mailing Address: City: Province: Postal Code: Contact Phone: Phone: Fax: Contact E-mail: 2 Employer/Supervisor Contact Name and Title:

Accident Details

3 Date/time of accident: Date/time scheduled shift started: Date/time scheduled shift ended: 4 Date accident/injury reported to employer: To whom was the accident/injury reported?: Phone Number: 5 Describe fully, based on the information you have, what happened to cause this injury or disease. Please describe what the worker was doing, including details about any tools, equipment, materials, etc., the worker was using. State any gas, chemicals or extreme temperatures worker may have been exposed to: Motor vehicle accident? Cardiac condition/injury? Letter attached? 6 Location where the accident happened (address, general location or site): Were the worker's actions at the time of injury for the purpose of your business? Were the actions part of the worker's regular duties?

Injury Details

What part of body was injured? (hand, eye, back, lungs, etc.) Left side Right side

What type of injury is this? (sprain, strain, bruise, etc.)

Employer's Signature:

Date:



Worker's Last Name:	Worker's First Name:	Initial:
Social Insurance #:	Date of Birth: <small>(Year / Month / Day)</small>	

7 Return to Work Details

a. Will/did you pay the worker regular pay while off work? Yes No Has the worker returned to work? Yes No

b. Date and time worker first missed work: (Year / Month / Day) Time: ____:____ a.m. p.m.

c. If the worker has returned to work, indicate date: (Year / Month / Day) Time: ____:____ a.m. p.m.

Current work status: Regular work duties, or Modified work duties Regular hours of work, or Modified hours of work: ____ hrs per ____

Pre-accident rate of pay, or Revised rate of pay: \$ ____ per ____

If the worker is working modified duties, please describe: _____

d. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? Yes No Was offered but the worker declined

e. Approximate return to work date: (Year / Month / Day) Does the worker have more than one position at your company? Yes No

8 Employment Type Details (Complete A or B or C. Select the worker's type of employment.)

A Permanent position employed 12 months of the year: Full Time Part Time Irregular/Casual

or **B** Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs): Seasonal worker Summer Student Temporary

Position start date: (Year / Month / Day) Position end date: (Year / Month / Day) Estimated Actual

How many months or days per year do you employ workers in this position? _____

or **C** Alternate employment: Sub contractor Piece work Vehicle owner/operator Welder owner/operator

Self-employed Volunteer Commission Other

Does the worker incur expenses to perform the work (substantial materials, heavy equipment, larger tools, etc.)? Yes No

Will the worker receive a T4? Yes No

9 Earnings Details Earnings information contact name (please print): _____

Earnings contact phone number: _____ Earnings contact e-mail: _____

Choose A or B:

A Gross earnings for the period of one year prior to the date of injury or date the worker was hired if less than one year: \$ _____ from: (Year / Month / Day) to: (Year / Month / Day)

Was any time missed from work **without pay** during the above period, excluding vacation? (eg. maternity, sick, WCB benefits) Yes No

Dates and reasons: _____

or **B** Worker's hourly rate of pay at time of accident: \$ _____

Additional taxable benefits:

Vacation Pay Taken as time off with pay OR Paid on a regular basis % _____

Shift Premium Gross earnings: \$ _____ from: (Year / Month / Day) to: (Year / Month / Day)

Overtime Gross earnings: \$ _____ from: (Year / Month / Day) to: (Year / Month / Day)

Other Gross earnings: \$ _____ from: (Year / Month / Day) to: (Year / Month / Day)

10 Hours of Work Details

a. Number of hours (not including overtime): _____ per Day Week Shift cycle Other: _____

b. Does the work schedule repeat? No Yes → Date shift cycle commenced: (Year / Month / Day)

	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Hours per day:	_____	_____	_____	_____	_____	_____	_____
Hours per day:	_____	_____	_____	_____	_____	_____	_____
Hours per day:	_____	_____	_____	_____	_____	_____	_____

Mark hours worked for one complete work schedule (use zero for days off):

Average regular hours worked per week (not including overtime): _____

IMPORTANT Circle day of injury. See instructions

or if your schedule is more than 21 days, attach a copy of the schedule.