**WorkSafeBC**

**Employer’s Report of Injury or Occupational Disease**

As an employer, the *Workers Compensation Act* requires you to submit this report within three days of an injury to one of your workers, even if you disagree with the claim. By submitting your report promptly, you avoid penalties and delays in the adjudication of the claim. Please report using one of the following options:

1. **Online** — The quickest and easiest option: The online screen application customizes questions to the worker’s injury. You can save your report and update it later with new information. Once submitted, you can follow the status of the claim online. Go to worksafebc.com and select “Report injury or illness.”

2. **Fillable PDF form**: Type in your details online, print the form, and submit it by fax or mail. Go to worksafebc.com and select “Report injury or illness.”

3. **Paper form**: Clearly print details, sign the form, and submit it by fax or mail.
   - Fax: 604.233.9777 in Greater Vancouver or toll-free within BC at 1.888.922.8807
   - Mail: WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

### Employer information

**Employer’s name (as registered with WorkSafeBC)**

Simon Fraser University

**WorkSafeBC account number**

765007

**Classification unit number**

765007

**Operating location number**


<table>
<thead>
<tr>
<th>Employer address line 1 (mailing)</th>
<th>Employer contact last name</th>
<th>Extension</th>
<th>Employer contact telephone (and area code)</th>
<th>Employer contact fax (and area code)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8888 University Drive</td>
<td>Jackie</td>
<td></td>
<td>778-782-6698</td>
<td>778-782-6873</td>
</tr>
<tr>
<td>Employer address line 2 (mailing)</td>
<td>Employer payroll contact last name</td>
<td>Extension</td>
<td>Employer payroll contact telephone (and area code)</td>
<td>Employer payroll contact fax (and area code)</td>
</tr>
<tr>
<td>Country (if not Canada)</td>
<td>BC</td>
<td></td>
<td>V5A 1S6</td>
<td>778-782-6698</td>
</tr>
</tbody>
</table>

### Worker Information

**Worker last name**

First name

Middle initial

Social insurance number

Gender

- □ M
- □ F

Date of birth (yyyy-mm-dd)

Home phone number (include area code)

Address line 1

City

Province/state

Country (if not Canada)

Postal code/zip

Address line 2

<table>
<thead>
<tr>
<th>1. What is the worker’s occupation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Permanent</td>
</tr>
<tr>
<td>□ Temporary</td>
</tr>
<tr>
<td>□ Full time</td>
</tr>
<tr>
<td>□ Part time</td>
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<tr>
<td>□ Apprentice</td>
</tr>
<tr>
<td>□ Volunteer</td>
</tr>
<tr>
<td>□ New entrant to workforce</td>
</tr>
<tr>
<td>□ Self-employed</td>
</tr>
<tr>
<td>□ Principal/partner or relative of employer</td>
</tr>
<tr>
<td>□ Fisher</td>
</tr>
<tr>
<td>□ Hired on a contract basis</td>
</tr>
<tr>
<td>□ Casual</td>
</tr>
<tr>
<td>□ Other (specify)</td>
</tr>
</tbody>
</table>

**Incident Information**

**5. Date of incident (yyyy-mm-dd)**

**Time of incident (hh:mm)**

**6. Period of exposure resulting in occupational disease (yyyy-mm-dd)**

**7. Did worker report injury or exposure to employer?**

**8. The injury or disease was first reported to employer on (yyyy-mm-dd)**

**10. Describe how the incident happened**

**11. Describe the injury in detail (what part of the body was injured)**

**12. Side of body injured**

- □ Left
- □ Right
- □ Both
- □ Not applicable

**13. Describe the work incident location (address, city, province) and where incident occurred (e.g. shop floor, lunchroom, parking lot)**

**14. Did the injury(ies) or exposure result from a specific incident?**

- □ Yes
- □ No
Employer's Report of Injury or Occupational Disease

If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

<table>
<thead>
<tr>
<th>Worker last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>WorkSafeBC claim number (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social insurance number</td>
<td>Personal health number (CareCard)</td>
<td>Date of incident (yyyy-mm-dd)</td>
<td>Date of birth (yyyy-mm-dd)</td>
</tr>
</tbody>
</table>

15. Contributing factors — select at least one, and as many as applicable
- Lifting
- Overexertion
- Repetitive activity
- Slip or trip
- Fall
- Struck
- Crush
- Sharp edge
- Fire or explosion
- Harmful substances in the work environment
- Animal bite
- Assault
- Motor vehicle accident
- Unsafe/job (please explain below)

16. Were there any witnesses?
- Yes  □  No  □

17. Did the incident occur in British Columbia?
- Yes  □  No  □

18. Were the worker's actions at time of injury for the purpose of your business?
- Yes  □  No  □

19. Did the incident occur on employer's premises or an authorized worksite?
- Yes  □  No  □

20. Did the incident happen during the worker's normal shift?
- Yes  □  No  □

21. Was the worker performing their regular duties at the time of the incident?
- Yes  □  No  □

22. Did the worker receive first aid?
- Yes  □  No  □ Date (yyyy-mm-dd)

23. Did the worker go to hospital, clinic, or visit a physician or qualified practitioner?
- Yes  □  No  □ Date (yyyy-mm-dd)

24. Are you aware of any recent pain or disability in the area of the worker's reported injury?
- Yes  □  No  □

25. Do you have any objections to the claim being allowed?
- Yes  □  No  □

Wage information

26. Did the worker miss any time from work beyond the date of injury or exposure?
- Yes  □  No  □

If no work was missed and no change to duties/pay, proceed to bottom of page to sign, date, and submit this report. If work was missed or if duties/pay have been modified, please answer all questions on this form.

27. Provide the base salary amount for this employment position at the time of injury

$ □ Hourly  □ Daily  □ Weekly  □ Monthly  □ Yearly

28. Does worker receive other amounts of compensation in addition to base salary?
- Yes  □  No  □

29. If worker is disabled from work, will you continue to pay:

   Base salary?
   □ Yes  □ No

   Other amounts of compensation in addition to base salary?
   □ Yes  □ No

   Will worker receive vacation pay on every cheque?
   □ Yes  □ No

   If yes, vacation pay __________%

Please select check boxes for any of the following amounts worker receives in addition to base salary AND provide the amount for each:
- Tips and gratuities $_________  □  Room and board $_________
- Shift differential $_________  □  Other $_________
- Overtime $_________

30. Provide the amount of gross earnings for the past 3 months or 12 weeks prior to the date of injury or exposure

$ □ 3 months  □ 12 weeks

31. Does the worker have a fixed-shift rotation?
- Yes  □  No  □

32. If no, please explain

33. If yes, show the normal work week by entering the paid hours

<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
</tr>
</thead>
</table>

34. Did the worker continue to work past day of injury?
- Yes  □  No  □

35. Last day worked (yyyy-mm-dd) __________

36. Number of hours scheduled to work on last day worked __________

37. Number of hours worked on last day __________

38. Number of hours paid by employer on last day worked __________
If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

Worker last name | First name | Middle initial | WorkSafeBC claim number (if known)
---|---|---|---
Social insurance number | Personal health number (CareCard) | Date of incident (yyyy-mm-dd) | Date of birth (yyyy-mm-dd)

**Return-to-work information**

39. Has the worker returned to work?
- Yes  - No

40. If Yes: Date (yyyy-mm-dd)
Since the return to work, have the worker’s duties, hours of work, work schedule, and/or rate of pay changed?
- Yes  - No

41. If No: Do you have any modified or transitional duties available?
- Yes  - No
Have the modified or transitional duties been offered to the worker?

42. If yes, please describe modified or transitional duties

**Signature and report date**

43. Employer signature  44. Employer title  45. Date of report (yyyy-mm-dd)

For assistance, please call our Claims Call Centre at 604.231.8888 or toll-free within Canada at 1.888.967.5377, M-F, 8:00 a.m. to 6:00 p.m.

Please note: If you have concerns with this claim, please contact the officer handling the claim at the WorkSafeBC office to make known your objections or you may submit a letter detailing your specific concerns. **Impartial advice on WorkSafeBC claims** — To ensure you have an opportunity to obtain impartial advice on WorkSafeBC claims matters, the BC legislature has provided impartial advisers. **Employers’ Advisers** are available to provide independent advice or clarification on a WorkSafeBC claim related to your firm. For additional information on the Employers’ Advisers, please refer to their website at www.labour.gov.bc.ca/eao/.

Lower Mainland
604.713.0303 (Richmond)
Toll-free within Canada 1.800.925.2233

Abbotsford, Kamloops, Kelowna, Nanaimo, Trail, Prince George, Victoria
Toll-free within Canada 1.800.925.2233

WorkSafeBC collects information on this form for the purposes of administering and enforcing the Workers Compensation Act. That Act, along with the Freedom of Information and Protection of Privacy Act, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC’s freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.