



Reset Form

Click on any field to start editing.

### Worker's Initial Report of Injury

WCB claim number: \_\_\_\_\_

Reporting options: 1) WCB Teleservice 1.800.787.9288 2) www.wcsask.com 3) Fax

#### Section A: Worker Information

Name, address, postal code	Occupation: _____ Social Insurance Number: _____ Provincial Health Number: _____ Date of birth: (MM/DD/YYYY) Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male Phone: _____ Best time to reach you? _____ Email: _____
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#### Section B: Employer Information

Name, address, postal code Regina Public Schools 1600 4th Avenue Regina SK S4R 8C8	WCB firm number: _____ Industry rate code: _____ Employer contact person: <u>Workplace Health &amp; Wellness</u> Phone number of contact: <u>(306) 523-3129</u>
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#### Section C: Injury Information

1. Injury date: (MM/DD/YYYY) 2. Reported to employer on: (MM/DD/YYYY) 3. Reported to: \_\_\_\_\_  
 4. Province of injury: \_\_\_\_\_ 5. Area of body injured: \_\_\_\_\_  
 6. How did the injury happen? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 7. Name of care provider: \_\_\_\_\_  
 8. Name of hospital or clinic: \_\_\_\_\_  
 9. Have you lost time from work, due to the injury, after the day of the injury?  Yes ... go to Section D  No ... go to Section F

#### Section D: Wage and Employment Information

10. First day off work due to this injury: (MM/DD/YYYY) Time: \_\_\_\_\_ a.m.  p.m.   
 11. Have you returned to work?  Yes  No If yes... enter the date and time: Date: (MM/DD/YYYY)  
 12. How are you paid? If regular salary: Hourly \$ \_\_\_\_\_ per hour \_\_\_\_\_ hours per week; If monthly \$ \_\_\_\_\_ per month  
 If non-regular:  Piecework  Contractor  Owner / Operator  Casual  Other (explain) \_\_\_\_\_  
 13. If you have regular days off mark which days:  Sun  Mon  Tue  Wed  Thu  Fri  Sat  
 14. Do you have other sources of employment income?  Yes  No If yes... attach employer names and phone numbers.  
 15. Will you be paid by your employer for time loss due to the injury?  Yes  No

#### Section E: Direct Deposit Information

If you wish to have your compensation payments made directly to your bank account, please choose one of the following options:

- Please attach a void cheque to this form (see example beside) and fax directly to the WCB at **1.888.844.7773**, or mail to the WCB; **OR**
- Have someone from your bank complete, sign and stamp a bank deposit request form and fax directly to Finance or mail it to the WCB; **OR**
- If you need assistance, call 1.800.667.7590.

Name / Nom P.O. Box / C.P. 000 City / Ville, Canada H0H 0H0	<b>Example / Exemple</b>	Cheque No. N° de chèque 0000000
Pay to the order of Payez à l'ordre de	<i>"Void" «Aval»</i>	\$ _____ Dollars
Signature		
⑈ 9999 ⑈ ⑆ 999999 9999 ⑆ 999 9999 9 ⑈		

Please note: If you change or close your account, let the WCB know in writing to avoid any delay in payment.

#### Section F: Declaration

I declare all the information provided is true and correct. I understand that criminal prosecution or penalties may result from any attempt to (1) obtain compensation benefits by fraudulent means and/or (2) prevent collection of compensation benefits.

(MM/DD/YYYY) \_\_\_\_\_ Please print & sign form before mailing/faxing.  
 Date Name (please print) Signature