



SASKATCHEWAN
WORKERS'
COMPENSATION
BOARD

200 - 1881 Scarth Street
Regina, Sask. S4P 4L1

Phone: (306) 787-4370
Toll Free: 1-800-667-7590 (Canada wide)
Fax: (306) 787-4311
Toll Free Fax: 1-888-844-7773 (Canada wide)

E1
Reset Form

Employer's Initial Report of Injury

WCB Claim No.:

Reporting Options: (1) WCB Telefile 1-800-787-9288 (2) WEB www.wcsask.com (3) Fax

Section A: Employer Information Click on any field to start editing.

Name, address, postal code	Type of Business: _____ Phone Number: _____ Contact Person: _____ E-mail: _____ Fax Number: _____ WCB Firm No.: _____ Industry Rate Code: _____
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Section B: Worker Information

Name, address, postal code	Specific Division (if applicable): _____ Occupation: _____ Social Insurance Number: _____ Personal Health Number: _____ Birthdate: D M Y Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Hire Date: D M Y
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Section C: Injury Information

1. Injury date: D M Y 2. Reported to employer on: D M Y 3. Province of injury: _____

4. Area of body injured: _____ 5. Name of healthcare provider: _____

6. How did the injury happen?

7. Has the employee lost time from work, due to the injury, after the day of injury? Yes; If "yes", go to question # 8 No; If "no", go to Section E

8. First day off and time employee left work due to this injury: Date D M Y Time _____ am pm

9. Has employee returned to work Yes No If "yes": Date D M Y Time _____ am pm

10. Do you have any reason to believe that this is not a work-related incident? Yes No If "yes", provide attachment(s) with explanation.

Section D: Wage and Employment Information

11. How is the employee paid? If Regular Salary: Hourly \$ _____ per hour, _____ hours per week; If Monthly \$ _____
 If Non-Regular: Piecework Sub-Contractor Owner / Operator Casual Other (explain) _____

12. Provide gross earnings for the 12 months preceding first day off work due to injury, starting with the most recent complete pay period. If less than 12 months, show earnings for actual period: Gross earnings \$ _____ from D M Y to D M Y

13. Time lost during the gross earning period due to: (a) Unpaid sickness _____ days; (b) Prior WCB claims _____ days; (c) Lack of work _____ days;
 (d) Other _____ days, explain _____

14. Normal working hours for employee: From _____ am pm to _____ am pm Shift work involved Yes No

15. Does the employee have regular days off? Yes No If "Yes", circle which days off: Sun Mon Tue Wed Thu Fri Sat
 If "No", circle the days off for the month of the injury, plus one month before and one month after first day off due to injury.
 MONTH BEFORE INJURY PERIOD: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
 MONTH OF THE INJURY: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
 MONTH AFTER INJURY PERIOD: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

16. TD1 Exemptions: Single Spouse, if partial provide: Provincial amount \$ _____ Federal amount \$ _____
 Other: \$ _____ No. Children 18 years or under _____

17. Should compensation payments be made to: Employee, OR Employer? 18. Will employee be paid for statutory holidays? Yes No

Section E: Declaration I declare that all the information provided is true and correct to the best of my knowledge.

D M Y Date	Name (please print)	Title	Please print & sign form before mailing/faxing. Signature
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