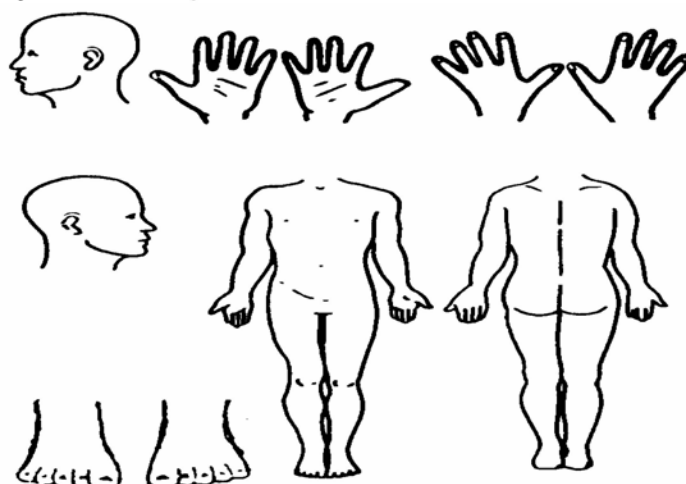


Mail To: P.O. Box 757, Charlottetown, Prince Edward Island C1A 7L7
 Drop Off: 14 Weymouth Street
 Website: www.wcb.pe.ca

Phone: (902) 368-5680
 Fax: (902) 368-5696
 Toll Free: 1-800-237-5049

Please submit this form within three (3) days after any notice of a workplace injury or occupational disease. Also, if this is a serious workplace injury please call, 902-628-7513, within 24 hours.

Please refer to user guide when filling out the Employer's Report Form

1. WORKER INFORMATION		<input type="checkbox"/> LOST TIME	<input type="checkbox"/> NO LOST TIME	<input type="checkbox"/> UNKNOWN						
Last Name:		First Name:		Initials:						
Address:										
City:		Date of Birth: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td style="width: 20px;">M</td><td style="width: 20px;">D</td><td style="width: 20px;">Y</td></tr><tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr></table>		M	D	Y				Sex: <input type="checkbox"/> M <input type="checkbox"/> F
M	D	Y								
Postal Code:		Province:		Job Title:						
Home Telephone:		Date of Hire: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td style="width: 20px;">M</td><td style="width: 20px;">D</td><td style="width: 20px;">Y</td></tr><tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr></table>			M	D	Y			
M	D	Y								
2. EMPLOYER INFORMATION										
Employer Firm Name:		Employer Firm Number:								
		Employer Operation Number:								
Address:		Is the worker a partner/director in this business? <input type="checkbox"/> Y <input type="checkbox"/> N								
City:		Does your firm have 20 or more workers? <input type="checkbox"/> Y <input type="checkbox"/> N								
Postal Code:		Province:		Contact Name:						
Company Telephone:		Contact Telephone:								
3. INJURY OR OCCUPATIONAL DISEASE INFORMATION COMPLETE EITHER a OR b OR c										
a) Please provide date and time of injury or specific incident.										
Date: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td style="width: 20px;">M</td><td style="width: 20px;">D</td><td style="width: 20px;">Y</td></tr><tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr></table>		M	D	Y				Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
M	D	Y								
Scheduled hours of employment on the day of the accident: From: _____ To: _____										
b) <input type="checkbox"/> The injury developed over a period of time.		c) <input type="checkbox"/> The injury is a recurrence of a prior injury.								
4. REPORT TO EMPLOYER										
Was the injury reported to the employer? <input type="checkbox"/> Y <input type="checkbox"/> N										
If yes, please provide the following: To Whom: _____ Job Title: _____										
Date: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td style="width: 20px;">M</td><td style="width: 20px;">D</td><td style="width: 20px;">Y</td></tr><tr><td style="height: 20px;"> </td><td style="height: 20px;"> </td><td style="height: 20px;"> </td></tr></table>		M	D	Y				Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
M	D	Y								
5. LOCATION OF ACCIDENT										
Did the injury occur on the employer's premises? <input type="checkbox"/> Y <input type="checkbox"/> N										
If no, where did it happen?										
6. WITNESSES										
Were there witnesses? <input type="checkbox"/> Y <input type="checkbox"/> N		Name:	Job Title:	Telephone:						
		Name:	Job Title:	Telephone:						
7. PREVIOUS PAIN OR INJURY										
Do you know of any previous pain or injury in the area of the worker's present injury? <input type="checkbox"/> Y <input type="checkbox"/> N										
If yes, please explain:										
8. PART OF BODY		9. ACCIDENT DESCRIPTION:								
a) Body Part Injured: _____ b) Circle area injured: 		Describe fully what happened: (If necessary, use a separate sheet)								

Please complete the other side

Submit Promptly

