Workplace Health, Safety & Compensation Commission
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Toll free fax: 1-800-276-5257
146 - 148 Forest Rd.
P.O. Box 9000
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Worker's Report of Injury

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This information is collected under the authority of the *Workplace Health, Safety and Compensation Act* to determine entitlement to benefits and manage your claim.

SECTION A - GENERAL INFORMATION

WORKER

1 Last name | First name | Initial | Date of birth yyyy/mm/dd | Gender ☐ M ☐ F

Mailing address | City / Town | Province | Postal code

Home telephone | Work telephone | Social Insurance Number | MCP

2 Occupation | Are you the owner / operator of this business? ☐ Yes ☐ No | Were you employed as part of a HRSDC program? ☐ Yes ☐ No

EMPLOYER

3 Employer | Telephone

Mailing address | City / Town | Street address *if different* | City / Town

Province | Postal code | Supervisor's name | Supervisor's telephone

SECTION B - INJURY / INCIDENT INFORMATION

4 Date / time of injury / incident yyyy/mm/dd hh:mm ☐ AM ☐ PM | Did this injury develop over time without a specific injury / incident? ☐ Yes ☐ No | Date / time injury / incident was reported to employer: yyyy/mm/dd hh:mm ☐ AM ☐ PM

5 Did this injury / incident occur outside Newfoundland and Labrador? ☐ Yes ☐ No

6 To whom was the injury / incident first reported? | Last name | First name | Occupation | Telephone

7 What part(s) of your body was affected? *Indicate right, centre or left, if applicable.*

8 How did the injury / incident occur or the condition develop?

9 Did the injury / incident happen on the employer's property or worksite? ☐ Yes ☐ No | Specify where:

10 Were there any witnesses to this injury / incident? ☐ Yes If *yes, please specify name and contact information, if available.* ☐ No

	Last name	First name	Address	Work telephone	Home telephone
1.					
2.					

11 Was the injury / incident caused by anything listed at right? ☐ Yes ☐ No *If yes, tick applicable:*

☐ Motor vehicle accident *(e.g., forklift, car, truck, ATV)*
☐ Malfunction of product / equipment
☐ Other: _____
☐ Person(s) not employed by your employer
☐ Slip and fall

If *yes* to Question 11, was someone else involved? ☐ Yes If *yes, please specify name and contact information, if available.* ☐ No

	Last name	First name	Address	Work telephone	Home telephone
1.					
2.					

SECTION C - MEDICAL INFORMATION

12 Did you seek medical attention? ☐ Yes ☐ No | Date of visit yyyy/mm/dd | Were you seen in emergency? ☐ Yes ☐ No If *yes*, which hospital? _____ | Did you require hospitalization for more than two days? ☐ Yes ☐ No

13 Name the health care person you saw during this first visit: | Last name | First name | Address *if known*

14 Name your family physician: | Last name | First name | Address *if known*

15 Have you experienced similar problems in the past? ☐ Yes *If yes, explain in chart below. If related to a previous claim, record the number.* ☐ No

Similar problems	Year	Part of body	Location *if applicable*	WHSCC claim number
1.			☐ Right ☐ Centre ☐ Left	
2.			☐ Right ☐ Centre ☐ Left	
3.			☐ Right ☐ Centre ☐ Left	

Worker's name | Social Insurance Number

SECTION D - RETURN-TO-WORK INFORMATION

16 Did you stop working beyond the day of the injury? ☐ No ☐ Yes →

When did you stop working beyond the day of the injury? yyyy/mm/dd hh:mm ☐ AM ☐ PM

Were your work duties and / or hours modified or changed? ☐ Yes ☐ No

Have you since returned to work? ☐ No ☐ Yes → When? yyyy/mm/dd

Have you been offered or participated in alternate / modified duties? ☐ Yes ☐ No

SECTION E - EARNINGS INFORMATION

Complete only if claim involves lost time / early safe return to work greater than the day of injury.

17 At the time of your injury / incident, were you working in a second job? ☐ Yes ☐ No

If *yes*, have you lost time / wages from the second job as a result of the injury / incident? ☐ Yes ☐ No

18 Are you receiving other benefits in relation to this injury / incident? ☐ Yes ☐ No

If *yes*, is it: ☐ Short-term or long-term disability insurance benefits ☐ Canada Pension Plan ☐ WHSCC benefits ☐ Other: _____

19 At the time of your injury, were you receiving EI benefits? ☐ Yes ☐ No

20 Indicate the personal income tax credits you are claiming:

- ☐ a. Basic personal amount
- ☐ b. Full equivalent to spouse amount (If not full amount, then d. applies)
- ☐ c. Number of children under age 18 you are claiming _____
- ☐ d. Other (complete a new TD1 and TD1NL available from Canada Revenue Agency at *www.cra.gc.ca*).

If nothing is indicated above, you will be assumed as (a) basic personal amount.

SECTION F - FISHER'S INFORMATION

To be completed by workers on a fishing vessel.

21 Vessel name | Vessel length (feet) | Are you an owner or part owner of the vessel? ☐ Yes ☐ No

22 Master's name | Master's telephone | Master's mailing address City/Town Province Postal code

23 Are your earnings based on a share of the catch? ☐ Yes *If yes, describe your share arrangement:* _____ ☐ No

	Fish buyer's information *If you need more space, please use an additional sheet.*					
	Name	Telephone	Fax	Gross sales	Start of fishing period yyyy/mm/dd	End of fishing period yyyy/mm/dd
1.						
2.						
3.						

Attach pay stubs or other verification from the fish buyer, if available.

SECTION G - INFORMATION ACCESS AUTHORIZATION

24 Do you authorize another individual (e.g., union representative, MHA) to act on your behalf and access your information regarding this claim? ☐ Yes ☐ No

This authorization will remain in effect until you notify the Commission of a change using Form 13.

Last name	First name	Address	Organization *if applicable*	Telephone

SECTION H - SIGNATURE, CONSENT AND DECLARATION (signing this consent enables the Commission to process your claim.)

25 I believe this is an injury related to my work and I declare that all information I have provided to the Commission is true and correct. I understand I must immediately inform the Commission if I return to, or become capable of, performing work of any kind.

I consent to the Commission collecting and using all information it considers relevant for the purposes of determining my entitlement to benefits and managing my claim under the *Workplace Health, Safety and Compensation Act (WHSC Act)*. This includes, but is not limited to, collecting and using information from physicians, hospitals, health care providers, and employers pertaining to my examinations, treatment, medical history, injury/incident and employment.

I consent to the Commission disclosing to my employer or my Employer's Authorized Representative, a summary of my injury costs, which is disclosed to the employer for the purpose of verifying claims' costs. I consent to the Commission disclosing to external physicians, hospitals and health care providers all relevant information necessary for the purpose of determining entitlement to benefits and managing my claim under the *WHSC Act*.

I understand information may be collected, used and/or disclosed for other purposes and/or disclosed to other parties only as permitted by law, including, but not limited to, the *WHSC Act*, the *Access to Information and Protection of Privacy Act*, and the *Personal Health Information Act*, and I agree that this consent is valid for the duration of my claim.

Name *please print* _____ Signature _____ Date yyyy/mm/dd

SECTION I - CO-OPERATION AND OBLIGATION

All workers and employers must co-operate in early and safe return to work. A re-employment obligation may exist if there are 20 or more workers with your employer and if you have been continuously employed for more than one year. Contact your employer to determine if this re-employment obligation applies to you.

If attaching additional information, put your first name, last name and Social Insurance Number at the top of each sheet.

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Additional Worker Information

Worker's role in early and safe return to work

The main focus of early and safe return to work is to enable you to remain at the workplace following an injury or to return to the workplace in a safe and timely manner if you have already lost time from work.

Going back to work may involve making changes to the duties and/or the hours of work. It may also involve changes to the workplaces such as acquiring equipment or other devices to help you with your return to work.

Staying in touch with work

It is important to stay connected to your workplace following an injury. If your injury prevents you from performing your regular job duties, both you and your employer are required to work together to identify suitable and available employment, even while you are receiving medical treatment for your injury.

During each medical appointment, your doctor will provide you with a copy of their report (form 8/10) for your records and a second copy to bring to your employer. The employer's copy of the doctor's report does not contain your personal medical information; it simply identifies your functional abilities as a result of the injury.

It is extremely important for you to provide this report to your employer by the next working day after each doctor's visit. This will enable you to assist your employer in identifying suitable job duties so you can continue working without aggravating your injury. If you work in a unionized environment, you may want to involve your union representative in this process.

Finding the right duties

When identifying early and safe return-to-work opportunities with your employer, the first priority should be to maintain the connection to your pre-injury job at some level. Where this is not possible, it is important to work with your employer to identify suitable and available employment that is within your physical capabilities. If you and your employer require any assistance during this process, you should contact your case manager.

Documenting a plan

Once you and your employer have identified suitable job duties that are in keeping with your abilities, you will complete an early and safe return-to-work plan that outlines the agreed upon schedule and progression of duties. If any change occurs to this plan, you must immediately notify your case manager.

Your early and safe return-to-work plan should also outline the scheduled hours and the hourly wage earned. This information will then be used to determine if there is any entitlement to compensation during your return-to-work process.

Communicating progress

Communication is critical during early and safe return to work. The frequency and method of communication between you and your employer will be determined by the employer's procedures. However, we recommend you contact your employer weekly during the early and safe return-to work-program. You should contact them immediately if there is an improvement or deterioration in your physical condition that could affect your return-to-work plan. It is also important to keep your case manager updated on your progress.

Worker's role in occupational health and safety (OH&S)

- Worker’s duties:
  - Protect your health and safety and that of co-workers and others at or near the workplace;
  - Co-operate with your employer, co-workers, OH&S committee/worker health and safety representative/workplace health and safety designate, and anyone exercising a duty imposed under OH&S legislation;
  - Follow instructions and training;
  - Report hazardous conditions; and
  - Properly use all safety equipment, devices and clothing.
- Workers' rights:
  - Know about workplace hazards;
  - Participate and assist in identifying and resolving OH&S issues; and
  - Refuse unsafe work.

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Instructions for Completing Worker's Report of Injury (Form 6)

Use this form when:

- You have a work-related injury / incident or recurring work-related injury or illness that results in any of the following:
  - medical attention;
  - loss of earnings; and / or
  - lost-time from work.

  This includes injuries or illnesses that occurred over time as well as those caused by an event.
- If you feel your current symptoms are related to a previous work injury, complete this form based on your current situation, as opposed to restating what happened at the time of your initial injury. For example, for question 4 under section B *"Date/time of injury/incident,"* enter the date and time your current symptoms developed or the date a new incident happened which caused your current symptoms.
- If you are a partner, proprietor or independent operator (also referred to as owner/operator on this form) and you have experienced a work-related injury, coverage will be extended only when optional personal coverage has been purchased from the Commission.

Points to remember:

- Complete and accurate information is important to avoid delays in processing your claim.
- If you have additional information, attach additional pages and include your name and SIN on each page.
- Sign page 2 so we can process your claim.

Section A General Information

Occupation & Employer Information

- This refers to your occupation and employer at the time of your injury / incident.

Section B Injury / Incident Information

How did your injury / incident occur or the condition develop?

- Explain how the injury / incident happened and what you were doing at that time. This may include information such as: sizes, weights and names of objects involved; description of any machinery, tools or vehicles used at the time of the injury / incident; environmental conditions (work area, temperature, noise, chemicals, gas, fumes); if another person was involved; or any other information you think is important.

  For example: "*I was moving boxes in the storage room. I lifted a 40-pound box from the floor to put on a shelf. I twisted to the right while lifting, and hurt my upper back."*
- If your condition developed over time, a detailed description of the work you do is helpful. Explain how often you do a particular task; the sizes and weights of objects involved; how long you have been doing this work; and if there have been any recent changes to your schedule and / or tools or products you use.

  For example: *"I am a cashier and continuously scan products for my eight-hour shift using my left arm. The products can weigh from a few ounces up to 10 pounds. The belt hasn't been working properly for the past three weeks and I reach further than I usually do to ring things in. Recently I started to have pain in my left elbow."*

Did the injury / incident happen on the employer's property or worksite?

- Detailed information as to where the injury / incident happened is important to process your claim. For example, if on the employer's premises, where did it occur? The shipping area, paint shop, or warehouse? If not on the employer's premises, where did it happen?

  For example: *"I work for a cleaning company and was working at a retail store when the injury happened. The store was ABC Clothing on Anywhere Street."*

Section D: Return-to-work Information

- You and your employer may be able to change your duties and / or hours so you can stay at work while you are receiving medical treatment for your injury. This is called early and safe return-to-work.
- An early and safe return-to-work plan should be developed in co-operation with your employer, based on the functional abilities information from your health care provider(s).

Section E: Earnings Information

- If you are off work for more than one day, or have an early and safe return-to-work plan of more than one day, you may be entitled to wage-loss benefits. You should complete this section so the Commission can make this determination.

Section H: Signature, Consent and Declaration

- Signing the Form 6 Consent enables the Commission to process your claim.
- For more information on your rights and our personal information practices please see our *Personal Information Privacy Statement*, available on line or by contacting the Commission.

*Additional information on the Commission's access, release and protection of your information can be found in Policy GP-01: "Information Protection, Access and Disclosure," available at **www.whscc.nl.ca** or by calling the Commission's Information Officers at **1-800-563-9000**.*