

Saskatchewan Workers' Compensation Board

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

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Name, Address, Postal Code Type of Business: Phone Number: Contact Person: E-mail: Fax Number: WCB Firm No.: Industry Rate Code: MCB Firm No.: Industry Rate Code: Specific Division (if applicable): Occupation: Social Insurance Number: Personal Health Number: Date of Birth: Gender: Male Female Hire Date: Section C: Injury Information 1. Injury date: Fatality? Yes No S. Province of injury: A. Area of body injured: S. Name of healthcare provider: G. How did the injury happen? 7. Has the employee lost time from work, due to the injury, after the day of injury? Yes go to question #8 No go to Section E Time a.m. p.m. p.m. P. Has employee returned to work? Yes No If "yes", what was the date employee returned: No go to Section E Time a.m. p.m. P. Has employee paid? If Regular Salary: Hourly \$ yes No If "yes", provide attachment(s) with explanation. Section D: Wage and Employment Information No go to Nomer / Operator Casual Other (explain) Casual Other (explain) Casual Plecework Sub Contractor Owner / Operator Casual Other (explain) Casual Other (explain) Casual Other (explain) Casual Other (explain) Casual Ca	Employer's Initial Report of Injury WCB Claim No:		
Name, Address, Postal Code Type of Business: Phone Number: Contact Persons: E-mail: Fax Number: Phone Number: P	Reporting Options: 1) WCBTelefile 1-800-787-9288) WEB www.wcbsask.com	3) Fax
Phone Number: Contact Person: E-mail: Fax Number: WCB Firm No.: Industry Rate Code: Section B: Worker Information Name, Address, Postal Code Section C: Injury Information Name, Address, Postal Code Section C: Injury Information 1. Injury date: Personal Health Number: Date of Birth: Hire Date: Section C: Injury Information 1. Injury date: Personal Health Number: Date of Birth: Hire Date: Section C: Injury Information 1. Injury date: Personal Health Number: Date of Birth: Hire Date: Section C: Injury Information 1. Injury date: Personal Health Number: Date of Birth: Hire Date: Section C: Injury Information 1. Injury date: Personal Health Number: Date of Birth: Hire Date: Section C: Injury Information 1. Injury date: Personal Health Number: Date of Birth: Hire Date: Section C: Injury Information 1. Injury date: Personal Health Number: Date of Birth: Hire Date: Section C: Injury Information 7. Has the employee lost time from work, due to the injury, after the day of Injury? Personal Health Number: Date of Birth: Hire Date: Section D: Wage and time employee left work due to this lipiny: Date: Personal Health Number: Date of Birth: Hire Date: 7. Has the employee lost time from work, due to the injury, after the day of Injury? Personal Health Number: Date of Birth: Hire Date: 8. First day off and time employee left work due to this lipiny: Date: No. If Yes', what was the date employee returned: No. In Jury Hire Personal No. If Yes', what was the date employee returned: No. In Jury Hire Personal No. If Yes', what was the date employee returned: No. In Jury Hire Personal No. If Yes', what was the date employee returned: No. In Jury Hire Personal No. In Jury Hire Per	Section A: Employer Information		
Contact Person: E-mail: Fax Number: WCB Firm No: Industry Rate Code: Section B: Worker Information Name, Address, Postal Code Section C: Injury Information Section C: Injury Information Injury date: Section C: Injury Information Injury date: Fatality? Section C: Injury Information Injury date: Section C: Injury Information Injury date: Section C: Injury Information Injury date: Section D: Was a manual of both injury, after the day of injury: Section C: Injury Information Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury, after the day of injury? Injury date: Section D: Was a manual of both injury date: Section D: Was a manual of both injury date: Section D: Was a manual of both injury date: Section D: Was a manual of both injury date: Section D: Was a manual of both injury date: Section D: Was a manual of both injury date: Section D	Name, Address, Postal Code	Type of Business:	
E-mail:		Phone Number:	
Fax Number:		Contact Person:	
Section B: Worker Information Section B: Worker Information Specific Division (if applicable): Occupation: Social Insurance Number: Personal Health Number: Date of Birth: Gender: Male Female		E-mail:	
Specific Division (if applicable): Occupation: Specific Division (if applicable): Occupation: Social Insurance Number: Personal Health Number: Date of Birth: Gender: Male Female F		Fax Number:	
Section B: Worker Information Name, Address, Postal Code Specific Division (if applicable): Occupation: Social Insurance Number: Personal Health Number: Date of Birth: Date of Birth: Gender: Male Female Hire Date: Section C: Injury Information 1. Injury date: Section C: Injury Inj		WCB Firm No.:	Industry Rate Code:
Specific Division (if applicable): Occupation: Specific Division (if applicable): Occupation: Social Insurance Number: Date of Birth: Gender. Male Female Hire Date: Female Hire Date: Section C: Injury Information Injury date: Fatality? Yes No No Section C: Injury Information Injury date: Fatality? Yes No Section D: Se	Section B: Worker Information		
Occupation: Social Insurance Number: Personal Health Number: Date of Birth: Gender: Male Female Female Female Hire Date:		Specific Division (if appli	cable):
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Date of Birth:			
Hire Date:			
1. Injury date:			co.i.ac.iina.c
1. Injury date:	Section C: Injury Information		
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?		No	
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?	2. Reported to employer on: 3. Province of injury:		
6. How did the injury happen? 7. Has the employee lost time from work, due to the injury, after the day of injury?			
7. Has the employee lost time from work, due to the injury, after the day of injury?	·		
8. First day off and time employee left work due to this injury: 9. Has employee returned to work? 10. Do you have any reason to believe that this is not a work-related incident? 11. How is the employee paid? If Regular Salary: Hourly 12. Provide gross earnings for the 12 months preceding first day off due to the work injury: 13. Time lost during the gross earnings period due to: (a) Unpaid sickness: (d) Other 13. Time lost during the gross earnings period due to: (a) Unpaid sickness: (d) Other 14. Normal working hours for employee: From 15. Does the employee have regular days off? 16. Tyles mark the days off for the month of the injury, plus one month before and one month after first day off due to injury. 17. Should compensation payments be made to: 18. First day off due to that was the date employee returned: 18. Time lost during the gross earnings period. 19. Time lost during the gross earnings period due to: 10. Owner / Operator 10. Casual 10. Other (explain) 10. Other (explain) 10. Owner / Operator 10. Casual 10. Other (explain) 10. Other (explain) 10. Owner / Operator 10. Casual 10. Other (explain)	6. How did the injury happen?		
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 due to the work injury: \$ If less than12 months, provide gross earnings and time period: \$ from to 13. Time lost during the gross earnings 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 a.m p.m To a.m p.m Shift work involved Yes No 15. Does the employee have regular days off? Yes No If "Yes", mark which days off: Sun Mon Tue Wed Thu Fri Sat If "No", mark 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 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 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 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 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 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 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 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 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 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 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	8. First day off and time employee left work due to this injury: Dat 9. Has employee returned to work? Yes No If "9.	e: yes" , what was the date employee	a.mp.m returned:
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			Federal amount \$
Section E: Declaration I declare that all the information provided is true and correct to the best of my knowledge.			
	Section E: Declaration I declare that all the information	ition provided is true and con	rect to the best of my knowledge.
Date Name (please print) Title Signature	Date Name (please print)	Title	Signature