

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

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

Worker Information		Please print		Claim Number (if known)	
Last Name:		First Name and Initials:			
Address:			Provincial Health (PHN) #		
City:		Province:		Date of Birth: M D Y	
Postal Code:		Telephone:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Job Title at time of injury:			Email:		

Employment Information		
Employer's Name:	Dept. Name:	Supervisor's Name:
Address:		Telephone:
City:	Province:	Postal Code:

Injury/Accident or Occupational Disease Information		
<p>1 Provide time and date of injury/accident or occupational disease. Time: <input type="checkbox"/> am <input type="checkbox"/> pm M D Y</p> <p>Or did this condition develop over a period of time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, you will need to complete a Progressive Injury Questionnaire which is available on the WCB website or by contacting the WCB office.</p>		
<p>2 Was it a relapse or recurrence of an earlier work related condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was your initial injury? Did you file with WCB PEI? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain.</p>		
<p>3 When did you report the injury/accident or occupational disease to your employer? <input type="checkbox"/> am <input type="checkbox"/> pm M D Y</p> <p>To whom did you report the injury/accident? Name: Title: Telephone:</p>		
<p>4 If you delayed reporting for more than 1 day, why?</p>		
<p>5 If your workplace has a health and safety committee or representative, have they been notified of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>6 Did the injury/accident occur on your employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No Check which applies: <input type="checkbox"/> Prince Cnty. <input type="checkbox"/> Queens Cnty. <input type="checkbox"/> Kings Cnty. <input type="checkbox"/> Out of Prov.</p>		
<p>7 Was the work you were doing for the purpose of your employer's business? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was it part of your usual work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>8 a) Describe fully what happened to cause this injury/accident or occupational disease. Please mark area(s) affected below. Describe what you were doing and include any tools, equipment, materials, that you were using. Attach an extra page to fully explain if needed. Provide time and date of injury/accident:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>b) Were there witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No Give names and job titles.</p> </div> <div style="width: 35%;"> <p>Part of Body</p> <p><input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder</p> <p><input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Upper back</p> <p><input type="checkbox"/> Low back <input type="checkbox"/> Hip/thigh <input type="checkbox"/> Knee</p> <p><input type="checkbox"/> Ankle/Foot <input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> Other</p> </div> </div>		
<p>9 Did any person or factor outside your employment cause or contribute to the injury/accident or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Attach an extra page to fully explain.</p>		<p>Side</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Right</p>
<p>10 Did you receive medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, where were you first treated? Date: M D Y Time: <input type="checkbox"/> am <input type="checkbox"/> pm Provide doctor's name:</p>		
<p>11 If there was a delay in seeking treatment, explain. Attach an extra page to fully explain if needed.</p> <p>Were you off work after the day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>12 Have you had a similar injury before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? How did it happen? Was it work related? <input type="checkbox"/> Yes <input type="checkbox"/> No If work related, was it claimed at WCB PEI? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, attach extra page to explain.</p>		

13 Have you reported or claimed any injuries with any other WCB? Yes No
 Where? _____ When? _____
 For what condition? _____

Type of Employment Fill in A, B or C

Date you were hired?

M	D	Y

A Permanent Full Time Permanent Part Time

B Seasonal Work Summer Student Casual

Had this injury not happened, what would have been your last day of employment: Estimated or Actual

M	D	Y

With this employer how many weeks per year would this job last?

Do you have a second job? Yes No If yes, Employer's name: _____

Telephone: _____

C Sub Contract Piece Work Vehicle Owner/Operator Owner/Operator Other or Self Employed Explain on separate sheet.

Hours of Work State your usual hours (exclude overtime) per day _____ per week _____ per rotation _____

Does your work schedule repeat? Yes No How many weeks did you work in the previous year? _____

Show the three weeks prior to and including your injury, include hours and code if you work shifts. If regular schedule is more than 21 days, attach a copy. **Select day of injury.**

Code: D Days
E Evenings
N Nights

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
2 wks prior							
1 wk prior							
injury wk							

COMPLETE THE FOLLOWING TWO SECTIONS ONLY IF YOU HAVE MISSED TIME FROM WORK

Time Loss / Return to Work Information You are expected to discuss return to work options with your employer.

1 Date and time you first missed work: _____ Time: am pm

M	D	Y

2 Number of work days missed after the day of injury: _____ days

3 If you returned to work indicate the date: _____ Time: am pm
 regular duties modified duties

M	D	Y

4 What duties can you do until you are fit to return to your regular duties?

5 Who can we call about other work duties that are available? _____

Telephone: _____

Earnings Information This is necessary to determine your WCB benefit level.

SIN: _____

1 What is your regular gross weekly rate of pay? \$ _____ Hourly Rate? \$ _____

2 Did you have any earnings or income from other employers during the last 12 months? Yes No please attach copies of pay stubs and/or T4 slips.

3 Have you received Employment Insurance benefits in the last 12 months? Yes No

DECLARATION Please read carefully. Keep a copy of this form for your reference.

- I solemnly declare that I will notify my employer and my health care providers that I am filing a claim for Workers Compensation; that I will immediately notify the Workers Compensation Board of PEI of any monies received for work done by me and of any changes in my ability to return to employment.
- I understand that this will authorize the Workers Compensation Board to obtain or review information from any source whatsoever, including records of physicians, qualified practitioners or hospitals, a copy of records pertaining to examinations, treatment, history and employment of the undersigned.
- I hereby consent to the release of information to my employer concerning my functional abilities and limitations. I understand and agree it may be used to assist me to return to employment safely.
- I will notify WCB of any application for monies received from Long-Term Disability, Canada Pension Disability or from any other potential source of financial benefit as a result of this injury/accident.
- I understand that it is illegal to provide false or misleading information to WCB, its employees or service providers concerning my claim.
- I make this solemn declaration as if it had the same force and effect as if made under oath.

Date: _____

Name Printed: _____

Signature: _____

NOTE: The information on this form is collected under the authority of the section 6 (12) of the *Workers Compensation Act* and section 31 (a) and (c) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administering the compensation claims, determining employer assessment rates and monitoring workplace safety. If you have any questions about this collection of information, please contact WCB FOIPP Coordinator, Workers Compensation Board of PEI, 14 Weymouth Street, P.O. Box 757, Charlottetown, PE C1A 7L7, (902) 368-5680 or toll free at 1-800-237-5049.

NOTE: To improve its services, the WCB may contract an independent survey company to survey a sample of workers. The WCB does not know which workers will be contacted. If you are contacted, you can decide whether or not you want to take part. The research company does not share your personal responses with the WCB.

THE WORKERS COMPENSATION ACT PROVIDES AUTHORITY TO REFER WORKERS AND/OR THEIR FILES TO MEDICAL OR REHABILITATION PERSONNEL.

ARE THERE EXTRA PAGES ADDED? YES NO IF YES, HOW MANY?

Complete and submit this form by email, mail, fax or in person to: 14 Weymouth Street, P.O. Box 757, Charlottetown, PE C1A 7L7
 Email: workerservices@wcb.pe.ca Fax: 902-368-5696 Tel: 902-368-5680 or 1-800-237-5049