Saskatchewan Workers' Compensation Board

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Toll free: 1.800.667.7590
Fax: 306.787.4311
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E1

Click on any field to start editing.

Employer's Initial Report of Injury

WCB Claim No:

Reporting Options: 1) WCB Teleservice 1.800.787.9288 2) WEB www.wcbsask.com 3) Fax

Section A: Employer Information

Company name: ______

Address: ______

City: ______ Prov: ______

Postal Code: ______

Type of business: ______

Phone number: ______

Contact person: ______

Email: ______

Fax number: ______

WCB Firm no.: ______ Industry rate code: ______

Section B: Worker Information

Name: ______

Address: ______

City: ______ Prov: ______

Postal Code: ______

Phone number(s): ______ / ______

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
2. Reported to employer on: ______ 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 ... go to question #8 ☐ No ... go to Section E
8. First day off and time employee left work due to this injury: Date: ______ Time ______ ☐ a.m ☐ p.m
9. Has employee returned to work? ☐ Yes ☐ No If "yes" , what was the date employee returned: ______
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 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 OF 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

16. TD1 Exemptions: ☐ Single: ☐ Spouse, if partial: Provincial amount $ ______ Federal amount $ ______
    ☐ Other: $ ______ Number of 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.

Please print & sign form before mailing/faxing.

Date	Name (please print)	Title	Signature