WCB SASKATCHEWAN WORKERS' COMPENSATION BOARD

200 - 1881 Scarth Street
Regina, SK S4P 4L1

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

W1

Worker's Initial Report of Injury

WCB Claim No.:_____

Section A: Worker Information

Name, address, postal code

Occupation: _____

Social Insurance Number: _____

Personal Health Number: _____

Birthdate: _____

Home Phone:_____ Sex: ☐Male ☐Female

E-mail: _____

Section B: Employer Information

Name, address, postal code

Employer contact person: _____

Phone number of contact: _____

Section C: Injury Information

1. Injury date: D M Y _____ 2. Reported to employer on: D M Y _____ 3. Reported to: _____

4. Province of injury: _____ 5. Area of body injured: _____

6. How did the injury happen? _____

_____

_____

7. Name of healthcare provider: _____

8. Name of hospital or clinic: _____

9. Have you lost time from work, due to the injury, after the day of the injury? ☐Yes…If "yes" go to Section D ☐No…If "no" go to Section F

Section D: Wage and Employment Information

10. First day off due to this injury: D M Y _____ The time you left work:_____ ☐am ☐pm

11. Have you returned to work? ☐Yes ☐No If "yes"…enter the date you returned: D M Y _____

12. How are you paid? If Regular Salary: Hourly $_____ per hour, _____ hours per week; If Monthly $ _____ per month

If Non-Regular: ☐Piecework ☐Sub-Contractor ☐Owner/Operator ☐Casual ☐Other (explain): _____

13. If you have regular days off, circle which days: Sun Mon Tue Wed Thu Fri Sat

14. Do you have other sources of employment income? ☐Yes ☐No If "yes"… attach employer names and phone numbers.

15. Will you be paid by your employer for time loss due to the injury? ☐Yes ☐No

Section E: Direct Deposit Information

If you wish to have compensation payments made directly to your bank account, please complete this section. Attach a personalized cheque or deposit slip marked "VOID". The Workers' Compensation Board is authorized to credit payments to your account with the financial institution you have named.

Bank or Financial Institution	Branch Address	City	Province

Section F: Declaration

I declare that all the information provided is true and correct to the best of my knowledge

Date (D M Y)	Name (please print)	Signature

Revised 09/00

TO SPEED CLAIM PROCESSING, PLEASE FAX THIS FORM TO:
(306) 787-4311 OR TOLL-FREE IN SASKATCHEWAN 1-888-844-7773