WSCC Workers' Safety & Compensation Commission | ᐃᖅᑲᓇᐃᔭᖅᑎᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪ ᓇᓪᓕᐅᒃᑯᒫᓂᒃ ᖃᐅᔨᓴᖅᑎᑦ

First Medical Report

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN IT TO THE ADDRESS ON THE REVERSE

WSCC Claim Number	Health Care Provider (please print)

Worker Information

Last Name	First Name

Mailing Address (include postal code)	Community	Telephone (include area code)

Residential Address	Date of Birth	YY	MM	DD	Sex ❏ M ❏ F

Employer's Name	Worker's Occupation

Part of Body Injured	Date of Injury	YY	MM	DD	Date of Exam	YY	MM	DD

1. Would you like a WSCC doctor to contact you? ❏ Yes ❏ No

2. **Current work ability** ❏ Fit for regular work duties ❏ Unfit for regular work duties

   Start date for the return to regular work duties | YY | MM | DD |

   ❏ Capable of modified duites *(see categories on back page)*
   ❏ Limited ❏ Light ❏ Medium ❏ Heavy

   Duration of modified duties ❏ 1-7 days ❏ 8-14 days ❏ 15-21 days ❏ more ________________

   Start date for modified duties | YY | MM | DD |

3. Worker's account of injury. How did it happen?

4. Subjective Complaint(s)

5. Objective Findings

6. Describe any significant previous disease or injury

7. Investigations (Lab / X-rays, CT, etc.)

8. Diagnosis | ICD Code:

9. Prescribed treatment/advice/referrals

10. Has worker been hospitalized? ❏ Yes ❏ No *Hospital Name*

11. Is permanent disability probable? ❏ Yes ❏ No

12. Will worker be seen again? ❏ Yes ❏ No *When? By whom?*

CS003 1003

Worker's Name	Claim Number

Health Care Provider Information

Name of Health Care Provider (please print)	**WSCC Supplier Billing Number**
Telephone (include area code)	Fee Code ________ Fee Submitted ____________
	Fee Code ________ Fee Submitted ____________
Address (include postal code)	Report Form Fee ____ Fee Submitted ____________
	TOTAL $ ____________

Date of Exam	YY	MM	DD

Health Care Provider's Signature ______________________________ Date ____________________

I hereby certify that the above is a correct statement of services personally rendered by me.

NOTE TO SUPPLIERS:

We make payments on original invoices only. Faxed invoices or copies of invoices will not be paid.

RESPONSIBILITY OF HEALTH CARE PROVIDER

Excerpts from the Nunavut & NWT *Workers' Compensation Acts*

Report by health care provider	25. (1)	A health care provider who examines or treats a worker under this Act shall submit a report to the Commission.
Timing and contents of report	(2)	The report must be submitted within three days after the examination or treatment, and must contain the information required by the Commission.
Duty of health care facility	(3)	If a health care facility employs the health care provider referred to in subsection (1), the health care facility is responsible for ensuring that the report is submitted in accordance with this section.
Provision of information	30.	The Commission may require a claimant, an employer or a health care provider to provide any information that it considers necessary for it to determine a claim for compensation.

Excerpt from the Nunavut & NWT Workers' Compensation *General Regulations*

	7.2	A health care provider who fails to provide information required under section 30 of the Acts is liable under subsection 141(2) to a penalty of $250.

WORK CAPABILITIES

Reference: National Occupational Classification

Limited

Work activities involve handling loads up to 5 kg.
Examples:

- examining and analyzing financial information
- selling insurance to clients
- conducting economic and feasibility studies

Light

Work activities involve handling loads of 5 kg, but less than 10 kg.
Examples:

- repairing soles, heels and other parts of footwear
- filing materials in drawers, cabinets and storage boxes
- preparing and cooking meals

Medium

Work activities involve handling loads between 10 kg and 20 kg.
Examples:

- setting up and operating finishing machines or finishing furniture by hand
- measuring, cutting and applying wallpaper to walls
- adjusting, replacing or repairing mechanical or electrical components using hand tools and equipment

Heavy

Work activities involve handling loads of more than 20 kg.
Examples:

- operating and maintaining deck equipment and performing other deck duties aboard ships
- shovelling cement and other materials into cement mixers and performing other activities to assist in the maintenance and repair of roads
- measuring, cutting and fitting drywall sheets for installation on walls and ceilings

For Office Use Only

Supplier	RFP#	Billing Code	Entered By	Date	Authorized By	Date

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677
or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501

www.wscc.nt.ca • www.wscc.nu.ca

Ce formulaire est disponible en français.
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