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

Employer's Continuity Report

THE WORKER IS CLAIMING FURTHER ENTITLEMENT AS A RESULT OF THE INJURY SUSTAINED WHILE EMPLOYED BY YOU.

PLEASE ANSWER THE FOLLOWING QUESTIONS AND RETURN THE FORM TO OUR OFFICE SO A DECISION CAN BE MADE REGARDING THIS FILE.

Employer Information

Business Name:
Mailing Address (include postal code):
Telephone (include area code):

Worker Information

First Name:	Last Name:	
Mailing Address (include postal code):		
Telephone (include area code):	Date of Birth: YY / MM / DD	Social Insurance Number:

Claim Information

WSCC Claim Number:	Original Date of Injury:
Injury Type:	

In your observation, has the condition worsened over a period of time? If so, please give specifics.

To your knowledge, has the worker complained about his/her condition to fellow workers? If so, please provide their names and addresses.

Following the original injury, was the worker in any way limited in performing his/her usual duties? If so, please provide details of work limitations and the dates.

If another injury at work or elsewhere caused the symptoms to reappear, please provide details.

Any information received as a result of the claims process is confidential. Further use or disclosure of the information could result in a fine pursuant to the *Workers' Compensation Acts*.

Completed by (please print):	Signed at (City, Town, Village):	
Authorized Signature	Phone Number:	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

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Ce formulaire est disponible en français.