

Report of Injury

If you need assistance filling in this form, or more information, please contact our Tele-claim services.
 NWT Toll Free: 1-800-661-0792 • Nunavut Toll Free: 1-877-404-4407

IF A QUESTION DOES NOT APPLY, INDICATE WITH "N/A".

A – Worker Information					
First Name		Last Name		Also Known As	
Mailing Address			Community	Territory/Province	Postal Code <div style="display: flex; justify-content: space-around;"> </div>
Residential Address (if different than above)				Date of Birth <div style="display: flex; justify-content: space-around;"> M M D D Y Y </div>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Telephone (include Area Code) <div style="display: flex; justify-content: space-around;"> </div>		Cell (include Area Code) <div style="display: flex; justify-content: space-around;"> </div>		Email Address	
Social Insurance Number <div style="display: flex; justify-content: space-around;"> </div>		Preferred Language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Inuktitut <input type="checkbox"/> Other _____			
Job Title (no abbreviations)					
B – Employer Information					
Employer Name			Address		
Supervisor Name			Telephone (include Area Code) <div style="display: flex; justify-content: space-around;"> </div>		
Do you work for this employer in a province or territory other than the Northwest Territories or Nunavut? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____					

The WSCC may use this information for the administration of legislation under our authority, including the *Workers' Compensation Acts*, the *Safety Acts*, and/or the *Mine Health and Safety Acts*, and their associated *Regulations*, and to contact you in relation to the requirements under the relevant legislation.

The WSCC may only use my personal information, as provided here for the sole purpose of conducting an investigation for my compensation claim. The WSCC may gather more information on my work incident and medical and work history to administer my claim for compensation. For that purpose only, the WSCC may disclose some personal information to my employer, medical personnel, and other relevant third parties.

Having read the requirements above, I understand and authorize the WSCC to collect and provide such information from all necessary sources.

Initial _____ Part of the body injured _____ Injury date: MMDDYY

I understand and acknowledge that incomplete information from me may delay my claim.

It may be a criminal offence to work and earn income while receiving workers' compensation benefits without the WSCC's approval.

Signature: _____

Date: MMDDYY

Witness: _____

Date: MMDDYY

It is your responsibility when providing an email address to ensure reasonable safeguards are in place to protect the confidentiality and security of your personal information within your email account.

PLEASE PROCEED TO 2ND PAGE. →

Worker's Full Name:

D – Past Injuries

12. Have you previously injured or experienced ongoing pain in the same body part? Yes No
If yes, please explain. Include dates if possible.

13. Do you have any previous compensation claims with the WSCC, or any other workers' compensation board? Yes No
If yes, provide dates and nature of injury.

E – Return to Work

14. Did your employer offer you modified or alternative work? Yes No
If yes, what are the modified duties? When?
MM DD YY

15. Did you return to work? Yes No If yes, Light Duties Regular Duties
If no, when do you expect to return to work (e.g., a month, 2 days, etc.) _____ When?
MM DD YY

F – Employment

16. Worker's Type of Employment

Permanent

- Term (Over 1 year) Relief
- Full / Part-time Permanent Other
- Apprentice

Non-permanent

- Term (Under 1 year) - Apprentice
Term End Date: MM DD YY Seasonal -
 Summer Student Start Date: MM DD YY
 Casual End Date: MM DD YY

G – Schedule Information

17. Number of days on _____
Number of days off _____

18. Regular hours per day _____

19. Regular hours per rotation _____

H – Wage Information (Please complete all questions.)

20. What is your hourly rate of pay? _____ / hour. What are your annual gross earnings? _____

21. Do you regularly work overtime? Yes No
If yes, how many hours per day are overtime? _____ Provide an estimate of regular overtime hours _____ / day week month

22. Do you receive any other earnings? Please check all that apply.
 Vacation pay Uniform allowances Northern living allowance
 Other: (please specify) _____

23. Do you have a second job? Yes No If yes, did you miss time from this job due to your injury? Yes No
(If you have more than one employer, please list all employers and their contact information.)
Name of second employer: _____ Contact name: _____
Contact phone: MM DD YY

Wage Information (for tax purposes)

24. Marital Status Single Married Common Law Widowed Divorced

25. Number of Dependents _____

26. If married or common-law, does your spouse reside in the same territory/province as you? Yes No

WORKER'S CONSENT

I claim compensation for my work-related injury or disease and declare the information provided in support of my claim is true and accurate to the best of my knowledge and belief. I acknowledge it may be a criminal offence to make a false claim. Initial _____

PLEASE PROCEED TO 4TH PAGE. →

