

Worker's Full Name:

C – Incident Details

1. Which of the following did your injury/injuries, or exposure result from?
 A specific incident More than one incident If more than one incident, please explain _____

2. Date of Incident (if applicable) MM DD YYYY Time _____ AM PM 3. Place of Incident: Community _____ Territory/Province _____

4. Did you delay reporting for more than one day? Yes No If yes, why? (Please explain) _____

5. Did incident occur on employer's premises? Yes No If no, where did the incident occur? _____

6. Name and position of person you reported incident to:
Name _____ Position _____ Phone (include Area Code) _____

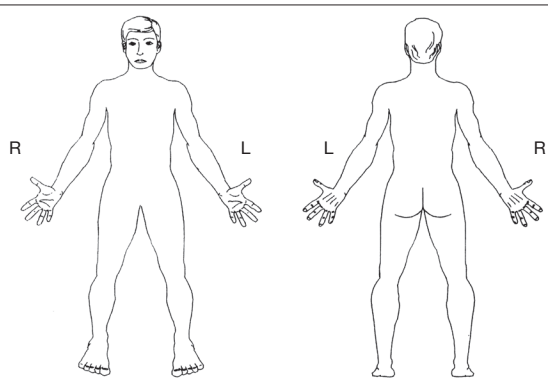
7. Did you stop working due to your injury? Yes No If yes, when? MM DD YYYY Time _____ AM PM

8. Which best describes the injury you are reporting?
 Physical Repetitive Strain Psychological Illness Exposure

9. How did your injury happen? Please describe the incident that led to your injury in as much detail as possible. (Please use space on last page if necessary)

10. Where in the workplace did the injury happen?

11. What part of your body did you injure? (left/right side, hand, eye, back, etc.) Please also indicate the body part on the diagram.



12. Describe any equipment, substances (gas/chemicals), extreme temperatures, or other people involved in the incident.

13. Did any person or factor outside your employment cause or contribute to the injury or incident?

14. IMPORTANT – Please list any witnesses.

Name	Address	Phone (include Area Code)
Name	Address	Phone (include Area Code)

15. Did you seek medical attention? Yes No

16. Where did you receive medical attention? When? MM DD YYYY Time _____ AM PM

17. If medical attention was given by First Aid or Medical Aid, please provide contact information.

First Aid:	Name	Phone (include Area Code)	Email
Medical Aid:	Facility Name		

PLEASE PROCEED TO 3RD PAGE. →

Worker's Full Name:

D – Past Injuries

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

19. 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

A safe and timely return to work helps with recovery and rehabilitation.

20. Have you discussed return to work options with your employer? Yes No

21. Did your employer offer you modified or alternative work? Yes No When?

MM	DD	YYYY
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If yes, what are the modified duties?

22. Did you return to work? Yes No If yes, Light Duties Regular Duties When?

MM	DD	YYYY
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If no, when do you expect to return to work (e.g., a month, 2 days, etc.)

23. Have you missed time from work due to this injury? (Note: This does not include missing time on the date the injury occurred) Yes No
If yes, please continue to the next section, **F – Employment**
If no, please proceed to the last page and complete the **Worker's Acknowledgement** section before submitting your form.

F – Employment

24. What type of employment do you have? A. Permanent B. Non-permanent
Complete employment type "A" or "B" (whichever applies):

A. Permanent

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

B. Non-permanent

Term/Contract (under 1 year) – Start Date

MM	DD	YYYY
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 End Date

MM	DD	YYYY
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Summer Student Casual Apprentice Seasonal – Start Date

MM	DD	YYYY
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 End Date

MM	DD	YYYY
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25. Do you work a rotation? Yes No
If no, please explain.

PLEASE PROCEED TO 4TH PAGE.

Worker's Full Name: _____

G – Schedule Information

Before your injury/incident, what was your work schedule?

26. Number of days on _____ 27. Regular hours per day _____ 28. Regular hours per rotation _____
Number of days off _____

29. Indicate days on for one full rotation. Write the hours scheduled below for each day worked. i.e. 8am-5pm; 7am-3pm, etc.

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Week 1							
Week 2							
Week 3							
Week 4							

30. Date rotation started MM DD YYYY 31. Date rotation ended MM DD YYYY

32. Are travel days included in the on/off work rotation? Yes No 33. Do you receive a travel allowance? Yes No
If yes, how much? \$ _____ per day, or \$ _____ per hour.

H – Wage Information (Please complete all questions and attach 3 recent pay stubs.)

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

35. 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

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

37. Do you have a second job? Note: Having another position with the same employer is considered 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 email _____ Contact phone (include Area Code) _____

Wage Information (for tax purposes)

38. Marital Status Single Married Common Law Widowed Divorced 39. Number of Dependents _____

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

PLEASE PROCEED TO 5TH PAGE. 

Please add any additional information in the space provided.

Worker's Acknowledgement:

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.

Name: _____

Signature: _____

Date:

MM	DD	YYYY

If you need assistance filling in this form, or more information, please contact our Tele-claim services.

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 • Email: reportsnwt@wscn.nt.ca

or

Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8501

Toll Free Fax: 1-866-979-8501 • Email: reportsnu@wscn.nu.ca

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Ce formulaire est disponible en français
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