



Employee Injury/Accident Report Form

Instructions for Injured Employees (or Designate) and Their Supervisors

NOTE: Personal information collected on this form is collected for the purposes of generating injury related statistics for the employer and in accordance with the Worker's Compensation Act, the submission of a worker's claim for compensation

Step 1	Employee Complete the Employee Injury/Accident Report Form	➔	Supervisor Sign the completed form and immediately submit/fax the completed form to Human Resources	➔	Spectrum Fax Number Human Resources 604-321-4144
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Step 2	Human Resources	➔	Sign the completed form and fax to DMI	➔	DMI Fax Number 604-552-3648
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If you require additional space for comments, please attach a separate sheet of paper and submit with the Employee Injury/Accident Report Form

SECTION A: EMPLOYEE INFORMATION		
Last Name:	First Name:	Employee's Phone:
Employer:	Site / Location:	
Employee's Address (No, St, Apt):	City/Town:	Postal Code:
Birth Date (MM/DD/YYYY):	SIN:	Position/Occupation:
Work Phone & Local:	Name/Phone # of Supervisor:	
SECTION B: ACCIDENT DETAILS		
Injury Date and Time:	Reported to:	
Witnesses:	Reported Date and Time :	
Type of Accident (check one):	<input type="checkbox"/> First Aid Only	<input type="checkbox"/> Medical Treatment <input type="checkbox"/> Lost Time
Description of the Incident:	Where did the Incident Occur:	
Body Part(s) Injured:		
Lost Time accident only if time was missed beyond date of injury	Date Last Worked:	Date of First Shift Missed:

SECTION C: MEDICAL TREATMENT		
Did employee obtain First Aid: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date and Time :	Name of First Aid Attendant:
Did employee seek medical attention: <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, indicate Date:	
Date employer notified of medical treatment:		

SECTION D: SCHEDULE AND EARNINGS INFORMATION

Employment Status (check all that apply):

<input type="checkbox"/> Permanent Full Time	<input type="checkbox"/> Casual/Irregular	<input type="checkbox"/> Student
<input type="checkbox"/> Permanent Part Time	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Registered Apprentice
<input type="checkbox"/> Temporary Full Time	<input type="checkbox"/> Contract	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Temporary Part Time		

Regular rate of pay \$ _____ Hour Other:

If worker has a fixed schedule, please identify days and hours worked:

Week 1							Week 2						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat

If not a full time employee, please identify average hours worked per week: _____

SECTION E: RETURN TO WORK (RTW)

Has the employee returned to work? Yes No

If YES, indicate date: _____ To: Regular Duties Modified Duties

If NO, has the employee been provided with a **written** modified work offer? Yes No

If YES to modified duties, please attach a copy of the modified work offer: Attached

I declare all the information I have given on this report is true and correct. I understand that by completing this form, the Disability Management Institute will submit a "Form 7" in accordance with Worker's Compensation Act and the Occupational Health and Safety Regulations and as such, I elect to claim compensation for the above mentioned injury(s) or disease(s), where said injury or disease has resulted in medical costs or lost time from work. I acknowledge that the WCB may disclose information from my claim to my employer or my employer's authorized agent for the purposes of the management of my claim in accordance with the law including the *Freedom of information and Privacy Act* and the *Personal Information Privacy Act*. I understand it is a serious offense to knowingly make a false claim or to work and earn income while receiving compensation without advising the WCB

Signature of Injured Employee: _____ **Date:** _____

Supervisor/Employer Contact: _____ **Signature:** _____ **Date:** _____

Do you have any concerns or relevant information regarding this claim you wish to discuss with DMI? Yes No

Comments: