

Worker Incident Report

Claim Number

3

Worker Information (Please type all dates as DD-MM-YYYY.)

Last Name		First Name	
Address		City	Province
Postal Code	Phone Number	Email	
Date of Birth (DD-MM-YYYY)		PHIN	
Social Insurance Number	Gender	Job Title	

Employer Information

Business Name		Address (include branch where applicable)	
City	Province	Postal Code	Phone Number

Injury Details

Date of incident (DD-MM-YYYY)	Area(s) of injury
Date reported to employer (DD-MM-YYYY)	Name and position to whom incident was reported
Please describe the incident in as much detail as possible. (Use separate sheet if necessary. If applicable, identify any witnesses.)	
City and province where incident occurred	
Did the incident occur on your employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, specify name and address of premises where incident happened.

Name and Address of Doctor(s) and/or Hospital(s) that Provided Treatment (Attach separate sheet if necessary.)

Name	Address	Date of Visit (DD-MM-YYYY)
------	---------	----------------------------

Time Loss and Wages (Only complete this section if you have missed time from work beyond the date of the incident.)

What was the last day and hour you worked following the incident? _____ (DD/MM/YYYY) at _____ Hour <input type="checkbox"/> AM <input type="checkbox"/> PM	
Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ (DD/MM/YYYY) at _____ Hour <input type="checkbox"/> AM <input type="checkbox"/> PM	
Were you paid wages by your employer while you were off work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have other sources of employment income? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many hours do you work per week? If it varies, please describe.	What are your regular days off? If it varies, please describe.
What is your current hourly wage? \$	What are your regular gross earnings? (Specify weekly, bi-weekly, etc.) \$
What is your marital status? <input type="checkbox"/> Single <input type="checkbox"/> Common-law <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	If married/common-law, is your spouse/partner working? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If your spouse is not working, do you claim them as a dependant for income tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No

Fax this form - in Winnipeg: 204-954-4999 | toll free: 1-877-872-3804
For faster claim reporting, please call 204-954-4321 | Toll free 1-855-954-4321

Worker's Name	Claim Number	3
---------------	--------------	---

Time Loss and Wages (Continued)

Are you personally allowed to claim a deduction on your current year Income Tax Return for:		
Dependant children age 18 years or younger? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many dependants?	
Disabled dependants age 18 years or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many dependants?	
Child care expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, estimate total deduction for current tax year. \$	
Spousal support payments? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, state monthly amount. \$	Total for the year \$
Have you applied for income from other sources? (e.g. EI, CPP, Social Insurance, Company Disability Plan, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe.	

Coverage

Was anyone not employed by your employer involved in the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give name and address.	
Are you a partner, director or sole proprietor of the company? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you a sub-contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify: <input type="checkbox"/> Construction <input type="checkbox"/> Logging	(Complete appropriate sections below.)
Are you an owner operator? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify: <input type="checkbox"/> Courier <input type="checkbox"/> Trucking <input type="checkbox"/> Towing	(Complete appropriate sections below.)
Please answer these questions if the incident occurred between Jan. 1, 1992 and Dec. 31, 2005.		
Are you a member of the family of your employer (or if the employer is a corporation, a family member of a director of the corporation)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, at the time of the incident did you reside with the employer or director? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Farming

Are you related to the farm owner? <input type="checkbox"/> Yes <input type="checkbox"/> No

Sub-Contractor or Owner Operator (Only complete if you are a sub-contractor or owner operator.)

Is your employer covering you under their WCB coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, are you registered with WCB? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you work in a partnership? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you employ other workers? <input type="checkbox"/> Yes <input type="checkbox"/> No

Sub-Contractor in Construction

Do you supply any materials or equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify.
--	-------------------------

Sub-Contractor in Logging

Do you supply any materials or equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify.
Were you cutting on the firm's timber sale, timber permit or sawmill license? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, on whose timber sale, timber permit or sawmill license were you cutting?

Owner Operator is a Courier

What is the gross vehicle weight? (This can be obtained from the Autopac registration.)

Owner Operator in Trucking

Do you haul within a 16 km radius of the city or town in which the home terminal is located? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a long distance driver? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you provide a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many vehicles do you provide?	

I understand that under *The Workers Compensation Act* the WCB can collect information about me to adjudicate and manage my claim and that information from my claim may be disclosed to my employer or employer representative for WCB program purposes, or may be released to others as authorized by legislation, including *The Workers Compensation Act*, *The Personal Health Information Act* and *The Freedom of Information and Protection of Privacy Act*. The information collected may be used to conduct WCB evaluations and surveys. Additionally, your email address may be used as a communication channel to share relevant information about the WCB or your claim. *The Freedom of Information and Protection of Privacy Act* allows the WCB to collect email addresses for this purpose. If you have any questions regarding the collection, use or disclosure of information on your claim, please contact the WCB's Access and Privacy Officer at (204) 954-4557 or toll free at 1-855-954-4321 extension 4557. If you have any other questions regarding your claim, please call the Claims Service Centre at (204) 954-4321 or toll free at 1-855-954-4321.
 Note: The information on this form is collected under the authority of sections 36(1) of *The Freedom of Information and Protection of Privacy Act*, 13(1) of *The Personal Health Information Act* and *The Workers Compensation Act*.

Release for Medical Information

I authorize persons in possession of medical and other information that the WCB determines relevant to this claim to release same to the WCB upon request.

Income Information from Canada Revenue Agency

To assist in determining benefits you may be entitled to, the Workers Compensation Board of Manitoba may request income tax information. This includes copies of your complete income tax return(s) and other taxpayer information including all supporting information slips and financial statements from the Canada Revenue Agency. If this information is required, you will be asked to provide authorization to the WCB.

Signature of the Worker X	Date (DD/MM/YYYY)
-------------------------------------	-------------------