

Workers Compensation Board of PEI

The Employer's Report may be submitted electronically with a WCB Online Services account. Visit www.wcb.pe.ca

Help your workers recover at work – Did you know that modified or alternate work can help an injured worker recover and can lower claim costs? To find out how, contact WCB Workplace Services.

ALL INFORMATION IN SECTIONS 1 THROUGH 8 MUST BE COMPLETED FULLY

1. WORKER INFORMATION			<input type="checkbox"/> LOST TIME	<input type="checkbox"/> NO LOST TIME	<input type="checkbox"/> UNKNOWN									
Last Name:		First Name:		Initials:										
Address:				City:										
Province:	Postal Code:	Home Telephone:		Date of Birth: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td>M</td><td>D</td><td>Y</td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table>		M	D	Y						
M	D	Y												
Job Title:		Employee #: <small>(if applicable)</small>	Date of Hire: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td>M</td><td>D</td><td>Y</td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table>			M	D	Y						
M	D	Y												
2. EMPLOYER INFORMATION														
Employer Firm Name:			Company Telephone:											
WCB Firm Number (Mandatory Field):			WCB Operation Number:											
Address:			Is the worker a partner/director in this business? Y N											
City:	Postal Code:	Province:	Does your firm have 20 or more workers? Y N											
Contact Name and Telephone:														
3. INJURY OR OCCUPATIONAL DISEASE INFORMATION COMPLETE EITHER a OR b OR c														
a) Please provide date and time of injury or specific incident.														
Date: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td>M</td><td>D</td><td>Y</td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table>		M	D	Y							Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.			
M	D	Y												
b) <input type="checkbox"/> The injury developed over a period of time.			c) <input type="checkbox"/> The injury is a recurrence of a prior injury.											
4. REPORT TO EMPLOYER														
Was the injury reported to the employer? <input type="checkbox"/> Y <input type="checkbox"/> N														
If yes, please provide the following: To Whom: _____ Job Title: _____														
Date: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td>M</td><td>D</td><td>Y</td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table>			M	D	Y							Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		
M	D	Y												
Did the worker seek medical treatment? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown														
5. LOCATION OF ACCIDENT														
Did the injury occur in PEI? <input type="checkbox"/> Y <input type="checkbox"/> N			Did the injury occur on the employer's premises? <input type="checkbox"/> Y <input type="checkbox"/> N											
If no, where did it happen? _____														
6. WITNESSES														
Were there witnesses? <input type="checkbox"/> Y <input type="checkbox"/> N		Name:		Telephone:										
		Name:		Telephone:										
7. PREVIOUS PAIN OR INJURY														
Do you know of any previous pain or injury in the area of the worker's present injury? <input type="checkbox"/> Y <input type="checkbox"/> N														
If yes, please explain: _____														
8. PART OF BODY			9. ACCIDENT DESCRIPTION											
Head	Neck	Shoulder	a) Describe fully what happened: (If necessary, use a separate sheet)											
Forearm	Wrist	Upper back												
Low back	Hip/thigh	Knee												
Ankle/Foot	Hearing Loss													
Other														
Side			b) Do you have any issues or concerns? <input type="checkbox"/> Y <input type="checkbox"/> N											
Left		Right	If yes, please explain: _____											

Please complete the other side

Submit Promptly

