wcb Saskatchewan Workers' Compensation Board

200-1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com

Phone: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free: 1.888.844.7773

E1

Click on any field to start editing.

Reset Form

Employer's Initial Report of Injury

WCB Claim No:

Reporting Options: 1) WCB Teleservice 1.800.787.9288 2) WEB www.wcbsask.com 3) Fax

Section A: Employer Information

Name, Address, Postal Code

Type of Business: Education
Phone Number: (306) 764-1571
Contact Person: Jamie Henry
E-mail: jhenry@srsd119.ca
Fax Number: (306) 763-4460
WCB Firm No.: A020550 Industry Rate Code: G1201

Section B: Worker Information

Name, Address, Postal Code

Specific Division (if applicable):
Occupation:
Social Insurance Number:
Personal Health Number:
Date of Birth: Gender: ☐ Male ☐ Female
Hire Date:

Section C: Injury Information

1. Injury date: Fatality? ☐ Yes ☒ No
2. Reported to employer on: 3. Province of injury:
4. Area of body injured:
5. Name of healthcare provider:
6. How did the injury happen?

7. Has the employee lost time from work, due to the injury, after the day of injury? ☐ Yes ... go to question #8 ☐ No ... go to Section E
8. First day off and time employee left work due to this injury: Date: Time ☐ a.m ☐ p.m
9. Has employee returned to work? ☐ Yes ☐ No If "yes" , what was the date employee returned:
10. Do you have any reason to believe that this is not a work-related incident? ☐ Yes ☐ No If "yes", provide attachment(s) with explanation.

Section D: Wage and Employment Information

11. How is the employee paid? If Regular Salary: Hourly $ per hour, hours per week; If Monthly $
If Non-Regular: ☐ Piecework ☐ Sub Contractor ☐ Owner / Operator ☐ Casual ☐ Other (explain)
12. Provide gross earnings for the 12 months preceding first day off due to the work injury: $
If less than12 months, provide gross earnings and time period: $ from to
13. Time lost during the gross earnings period due to: (a) Unpaid sickness: days; (b) Prior WCB Claims days; (c) Lack of work: days; (d) Other days (Explain):
14. Normal working hours for employee: From ☐ a.m ☐ p.m To ☐ a.m ☐ p.m Shift work involved ☐ Yes ☐ No
15. Does the employee have regular days off? ☐ Yes ☐ No If "Yes", mark which days off: Sun Mon Tue Wed Thu Fri Sat
If "No", mark the days off for the month of the injury, plus one month before and one month after first day off due to injury.

MONTH BEFORE INJURY PERIOD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MONTH OF INJURY PERIOD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MONTH AFTER INJURY PERIOD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

16. TD1 Exemptions: ☐ Single: ☐ Spouse, if partial: Provincial amount $ Federal amount $
☐ Other: $ Number of Children 18 years or under:
17. Should compensation payments be made to: ☐ Employee, OR ☐ Employer? 18. Will employee be paid for statutory holidays? ☐ Yes ☐ No

Section E: Declaration

I declare that all the information provided is true and correct to the best of my knowledge.

Please print & sign form before mailing/faxing.

Date | Name (please print) | Title | Signature