Report of Injury Form

EMPLOYEE
Seek first aid if required. Report injury to your manager/supervisor

EMPLOYER/SUPERVISOR
If needed, arrange for medical attention. Complete this form with the employee and send to Disability Management Institute (DMI) only if employee misses time from work and/or receives medical attention.
If you have questions call DMI toll free 1-866-963-9995

Fax: 1-888-994-9047
OR
Email: wcbclaims@mydmi.ca

SECTION A: EMPLOYEE INFORMATION

Employee Last Name:	Employee Fist Name:	Employee Phone Number:
Employee's Address:	City/Town:	Postal Code:
Birth Date (MM/DD/YYYY):	Social Insurance Number:	Email Address:
Employer:	Position/Occupation:	Site/Location:
Name of Supervisor:	Phone Number of Supervisor:	Classification Unit (CU – ex. 766017)

SECTION B: ACCIDENT DETAILS

Injury date and time:	Reported to:	
Witnesses:	Reported date and time:	
Type of Accident (check one): ☐ First Aid only ☐ Medical treatment ☐ Lost time		
Description of the incident:		
Where did the incent 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? ☐ Yes ☐ No	Date and time:	Name of First Aid attendant:
Did employee seek medical attention? ☐ Yes ☐ No	If YES, indicate date:	Date employer notified of medical treatment:

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SECTION D: SCHEDULE AND EARNING INFORMATION

EMPLOYMENT STATUS (check all that apply):

☐ Permanent full-time	☐ Casual/irregular	☐ Student
☐ Permanent part-time	☐ Seasonal	☐ Registered Apprentice
☐ Temporary full-time	☐ Contract	☐ Other: _____
☐ Temporary part-time		

Regular Rate of pay: $_____ ☐ Hour ☐ Other: _____

Vacation pay % _____

Vacation accrual loss while on WCB: ☐ Yes ☐ No

Is the employer continuing to pay the worker for the time missed beyond the date of injury? ☐ Yes ☐ No

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

Week 1

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Week 2

Sun	Mon	Tues	Wed	Thurs	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 regarding this claim you wish to discuss with DMI? (Please provide any relevant information below) ☐ Yes ☐ No

Comments:

Questions or concerns? Please feel free to contact Regency Advisory directly at 306-666-3377.

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