WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

TELECLAIM APPLICATION — WORKER

If you have any questions, please phone toll-free 1 888 967-5377.

Claim number	**Intake date** *(Document date: yyyy-mm-dd)* **2008-03-20**	Time **09:36 am**
CSR user ID *(entered by)* **IG14810**	Interpreter ID *(if applicable)*	
Advise worker that Language Line is a third-party provider, and that the interpreter may be located outside of Canada, and that no record of the conversation will be kept — only WorkSafeBC will have a written account. ☐ Worker has provided consent **Yes** ☐		

1. Other party information

Is somebody other than the worker reporting this incident? **Yes** ☐ **No** ☐		
Name **Select:**		
Mailing address		
City	Province **BC**	Postal code
Phone number *(please include area code)*	Relation to worker	

2. Worker information

Last name **Select:**	First name	Middle initial
Mailing address		
City	Province **BC**	Postal code
Phone number *(please include area code)*	Social insurance number	
Date of birth **Select: ,**	Personal health number	
Occupation		
Hand dominance **Right** ☐ **Left** ☐	Height	Weight

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Worker's last name	Worker's first name	Claim number

3. Employer information

Employer name *(as registered with WorkSafeBC)*		
Mailing address		
City	Province **BC**	Postal code
Contact name **Select:**	Phone number *(please include area code)*	
Location of plant or project where injury occurred *(if different than mailing address)*		
City	Province **BC**	Postal code
Employment start date **Select: ,**		
If employed elsewhere, other employer name(s) and information		

4. Incident and injury details

Date and time of injury Date **Select: ,** Time **Select:** **OR**	Period of exposure From **Select: ,** To **Select: ,** **OR**	Date symptoms started **Select: ,**
Date reported to employer **Select: ,**	Name of person you reported to *(title optional)*	
If not reported to employer, why?		
Were there any witnesses? **Yes** ☐ **No** ☐ ▶ If yes, please provide name and contact information		
Area of injury		
Describe how the injury occurred, listing all injuries reported *(including right or left if applicable)*		
Did you receive first aid? **Yes** ☐ **No** ☐ ▶ If yes, please provide date and name of first aid attendant Date **Select: ,** Name		

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Have you sought medical treatment for your injury? **Yes** ☐ **No** ☐

If yes, please indicate all that apply

Hospital ☐ Name Phone
Dr. Date seen **Select:** ,

Family doctor ☐ Name Phone
Date seen **Select:** ,

Walk-in clinic ☐ Name Phone
Dr. Date seen **Select:** ,

Diagnosis

Are you currently seeking any of the following treatments? *(please check all that apply)*

Physiotherapy ☐ **Chiropractic** ☐ **Massage therapy** ☐ **Acupuncture** ☐

Other ☐ Please specify

Name(s) of clinic(s) where above treatment is being sought	Date treatment began

Have you had any prior pain or disability in the same area as this injury?

Yes ☐ **No** ☐ ▶ If yes, please explain

Did the injury occur on your employer's premises?

Yes ☐ **No** ☐ ▶ If no, please explain

Was anyone else responsible for the injury?

Yes ☐ **No** ☐ ▶ If yes, please explain

Were your actions instructed by your employer?

Yes ☐ **No** ☐ ▶ If no, please explain

Did injury occur during a regularly scheduled shift?

Yes ☐ **No** ☐ ▶ If no, please explain

Did injury occur while performing your normal work duties?

Yes ☐ **No** ☐ ▶ If no, please explain

5. Time loss and wage details

Did you continue to work after the day of injury?

Yes ☐ **No** ☐ ▶ If yes, please provide date last worked, total hours worked, and number of hours you were paid on that day

Date last worked **Select:** , Total hours worked Hours paid

Have you lost time from work after the date of injury? **Yes** ☐ **No** ☐

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What is your employment status at time of injury?

Permanent full-time ☐ **Permanent part-time** ☐
Temporary ☐ **Casual** ☐ **On call** ☐
Labour contractor (owner/operator, subcontractor) ☐ **Principal of company** ☐

Gross earning at the time of injury?

$

Per: **Hour** ☐ **Day** ☐ **Week** ☐ **Bi-weekly** ☐ **Month** ☐ **Year** ☐

Are there any additions to regular wages?

Yes ☐ **No** ☐

Regular overtime ☐ **Expenses or allowances** ☐ **Piecework** ☐
Commission ☐ **Shift differential/premium** ☐ **Other** ☐

Vacation pay (%)	Will worker continue to earn vacation pay while off work due to injury? **Yes** ☐ **No** ☐ **Unknown** ☐

Show normal work week:

Week 1	S	M	T	W	T	F	S
Week 2	S	M	T	W	T	F	S

Do you work a fixed shift rotation?

Yes ☐ **No** ☐ ▶ If yes, please provide shift pattern including cycle start date

Cycle start date **Select:** ,

Days on	Days off
Days on	Days off
Days on	Days off
Days on	Days off
Days on	Days off

Date of first shift missed **Select:** ,	Is your employer paying you while off due to injury? **Yes** ☐ **No** ☐ **Unknown** ☐

Earnings information re other employment

6. Additional information/comments

7. Return-to-work details

Have you returned to work?

Yes ☐ **No** ☐ ▶ If yes, please provide date **Select:** ,

To full days, full regular duties?

Yes ☐ **No** ☐ ▶ If no, please explain

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While working these duties, is there any change to your hours of work, work schedule, or rate of pay?

Yes ☐ **No** ☐ ▶ If yes, please explain

The next two sections below are required only if the injured worker has not returned to work or return to work is not imminent (<7 days from Intake Date). Otherwise, proceed to Declaration and Acknowledgement.

When does the worker believe they would be able to return to work?

Date **Select:** , **OR** **Select:**

What type of work does the worker perform?	On a scale of 1–10 tell us how much pain you are experiencing today, with 1 being very little and 10 being the very worst
Select:	**Select:**

Checklist: *(please check when done)*

Is worker aware of any light/modified duties available at work from employer?	**Yes** ☐	**No** ☐
Was there an offer made by the employer to have worker return to light/modified duties?	**Yes** ☐	**No** ☐
Advise worker that he/she is expected to participate in a RTW program, if deemed medically able.	☐	
Advise worker to speak with doctor regarding a return to work/modified duties, etc.	☐	

8. Worker responsibilities

Checklist: *(please check when done)*

Advise worker to keep in regular contact with employer while recovering.	☐
Advise worker that he/she is expected to participate in any treatment prescribed, i.e. physiotherapy, and that WorkSafeBC will generally only pay for one type of treatment at any one time.	☐
Advise worker that while off work due to injury he/she is expected to see the doctor as often as prescribed, immediately if condition/symptoms worsen, or if worker cannot return to work when originally advised or as prescribed.	☐
Advise worker that he/she is expected to contact WorkSafeBC after each doctor's appointment (not treatment session) and provide an update on prognosis, change in diagnosis, and anticipated return-to-work date.	☐
Advise worker to contact WorkSafeBC when he/she returns to work.	☐
Advise worker to contact WorkSafeBC if they anticipate traveling (holiday) while off on injury claim.	☐
Advise worker to inform WorkSafeBC if he/she performs any work or earns income while receiving workers' compensation benefits	☐

9. Follow-up by other WorkSafeBC staff

No entitlement decisions have been made and the claim still requires review and adjudication by one of our claims officers. You may receive a call from a representative with specialized knowledge in order to clarify and/or gather further details which will facilitate the adjudication process.	☐

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10. Declaration and acknowledgement

You declare all the information you have given on this report is true and correct.
You understand it is a serious offence to knowingly make a false claim. ☐

This information is collected, used and disclosed under the authority of the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. WorkSafeBC may obtain and disclose information from the claim to your employer for the purpose of appeal, or may disclose such information to others in accordance with the law, including the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. ☐

The information on this form has been reviewed with the worker to ensure its accuracy; the above two statements have been read to the worker; and the worker has verbally acknowledged that they are understood

Yes ☐ **No** ☐

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