Clear Form 6

Safety Matters @ Work
Workers Compensation Board of PEI

WORKER'S REPORT — FORM 6

Mail To: P.O. Box 757, Charlottetown, Prince Edward Island C1A 7L7
Drop Off: 14 Weymouth Street
www.wcb.pe.ca

Phone: (902) 368-5680
Fax: (902) 368-5696
Toll Free: 1-800-237-5049

Worker Information — Please print

Case I.D. #(if known)

Last Name: First Name and Initials:

Address: Provincial Health (PHN) #

City: Province: Date of Birth: M D Y Sex: ☐ M ☐ F

Postal Code: Telephone:

Job Title at time of injury: WCB Firm #: Employee # *(if applicable)*:

Employment Information

Employer's Name: Dept. Name: Supervisor's Name:

Address: Telephone:

City: Province: Postal Code:

Injury/Accident or Occupational Disease Information

1 Provide time and date of injury/accident or occupational disease. Time: ☐ am ☐ pm M D Y

Or did this condition develop over a period of time? ☐ Yes ☐ No
If yes, you will need to complete a Progressive Injury Questionnaire which is available on the WCB website or by contacting the WCB office.

2 Was it a relapse or recurrence of an earlier work related condition? ☐ Yes ☐ No
If yes, when was your initial injury?
Did you file with WCB PEI? ☐ Yes ☐ No If no, explain.

3 When did you report the injury/accident or occupational disease to your employer? ☐ am ☐ pm M D Y

To whom did you report the injury/accident? Name: Title: Telephone:

4 If you delayed reporting for more than 1 day, why?

5 If your workplace has a health and safety committee or representative, have they been notified of the accident? ☐ Yes ☐ No

6 Did the injury/accident occur on your employer's premises? ☐ Yes ☐ No Check which applies: ☐ Prince Cnty. ☐ Queens Cnty. ☐ Kings Cnty. ☐ Out of Prov.

7 Was the work you were doing for the purpose of your employer's business? ☐ Yes ☐ No If yes, was it part of your usual work? ☐ Yes ☐ No

8 a) Describe fully what happened to cause this injury/accident or occupational disease. **Please mark area(s) affected below.**
Describe what you were doing and include any tools, equipment, materials, that you were using. Attach an extra page to fully explain if needed.
Provide time and date of injury/accident:

b) Were there witnesses? ☐ Yes ☐ No Give names and job titles.

Part of Body

☐ Head ☐ Neck ☐ Shoulder
☐ Forearm ☐ Wrist ☐ Upper back
☐ Low back ☐ Hip/thigh ☐ Knee
☐ Ankle/Foot ☐ Hearing Loss
☐ Other

Side

◯ Left ◯ Right

9 Did any person or factor outside your employment cause or contribute to the injury/accident or occupational disease? ☐ Yes ☐ No ☐ Unsure Attach an extra page to fully explain.

10 Did you receive medical treatment? ☐ Yes ☐ No
If so, where were you first treated?
Date: M D Y Time: ☐ am ☐ pm
Provide doctor's name:

11 If there was a delay in seeking treatment, explain. Attach an extra page to fully explain if needed.

Were you off work after the day of injury? ☐ Yes ☐ No

12 Have you had a similar injury before? ☐ Yes ☐ No If yes, when?
How did it happen?
Was it work related? ☐ Yes ☐ No
If work related, was it claimed at WCB PEI? ☐ Yes ☐ No If no, attach extra page to explain.

SUBMIT TO THE WORKERS COMPENSATION BOARD WITHIN SIX MONTHS.
PLEASE DO NOT LEAVE THE ORIGINAL FORM WITH YOUR EMPLOYER.

Revised November 2018

13 Have you reported or claimed any injuries with any other WCB? ☐ Yes ☐ No

Where? When?

For what condition?

Type of Employment **Fill in A, B or C**

Date you were hired? M D Y

A ☐ Permanent Full Time ☐ Permanent Part Time

B ☐ Seasonal Work ☐ Summer Student ☐ Casual

Had this injury not happened, what would have been your last day of employment: ☐ Estimated or ☐ Actual M D Y

With this employer how many weeks per year would this job last?

Do you have a second job? ☐ Yes ☐ No If yes, Employer's name: Telephone:

C ☐ Sub Contract ☐ Piece Work ☐ Vehicle Owner/Operator ☐ Owner/Operator ☐ Other or Self Employed Explain on separate sheet.

Hours of Work

State your usual hours (exclude overtime) per day _____ per week _____ per rotation _____

Does your work schedule repeat? ☐ Yes ☐ No How many weeks did you work in the previous year?

Show the three weeks prior to and including your injury, include hours and code if you work shifts. If regular schedule is more than 21 days, attach a copy. **Select day of injury.**

Code: **D** Days **E** Evenings **N** Nights

	☐ Sun	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri	☐ Sat
2 wks prior							
1 wk prior							
injury wk							

COMPLETE THE FOLLOWING TWO SECTIONS ONLY IF YOU HAVE MISSED TIME FROM WORK

Time Loss / Return to Work Information

You are expected to discuss return to work options with your employer.

1 Date and time you first missed work: Time: ☐ am ☐ pm M D Y

2 Number of work days missed after the day of injury: _____ days

3 If you returned to work indicate the date: Time: ☐ am ☐ pm M D Y

☐ regular duties ☐ modified duties

4 What duties can you do until you are fit to return to your regular duties?

5 Who can we call about other work duties that are available? Telephone:

Earnings Information

This is necessary to determine your WCB benefit level. **SIN:**

1 What is your regular gross weekly rate of pay? $ Hourly Rate? $

2 Did you have any earnings or income from other employers during the last 12 months? ☐ Yes ☐ No please attach copies of pay stubs and/or T4 slips.

3 Have you received Employment Insurance benefits in the last 12 months? ☐ Yes ☐ No

DECLARATION

Please read carefully. Keep a copy of this form for your reference.

1. I solemnly declare that I will notify my employer and my health care providers that I am filing a claim for Workers Compensation; that I will immediately notify the Workers Compensation Board of PEI of any monies received for work done by me and of any changes in my ability to return to employment.
2. I understand that this will authorize the Workers Compensation Board to obtain or review information from any source whatsoever, including records of physicians, qualified practitioners or hospitals, a copy of records pertaining to examinations, treatment, history and employment of the undersigned.
3. I hereby consent to the release of information to my employer concerning my functional abilities and limitations. I understand and agree it may be used to assist me to return to employment safely.
4. I will notify WCB of any application for of monies received from Long-Term Disability, Canada Pension Disability or from any other potential source of financial benefit as a result of this injury/accident.
5. I understand that it is illegal to provide false or misleading information to WCB, its employees or service providers concerning my claim.
6. I make this solemn declaration as if it had the same force and effect as if made under oath.

Date: _____ Name Printed: _____ Signature: _____

NOTE: The information on this form is collected under the authority of the section 6 (12) of the *Workers Compensation Act* and section 31 (a) and (c) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administering the compensation claims, determining employer assessment rates and monitoring workplace safety. If you have any questions about this collection of information, please contact WCB FOIPP Coordinator, Workers Compensation Board of PEI, 14 Weymouth Street, P.O. Box 757, Charlottetown, PE C1A 7L7, (902) 368-5680 or toll free at 1-800-237-5049.

NOTE: To improve its services, the WCB may contract an independent survey company to survey a sample of workers. The WCB does not know which workers will be contacted. If you are contacted, you can decide whether or not you want to take part. The research company does not share your personal responses with the WCB.

THE WORKERS COMPENSATION ACT PROVIDES AUTHORITY TO REFER WORKERS AND/OR THEIR FILES TO MEDICAL OR REHABILITATION PERSONNEL.

ARE THERE EXTRA PAGES ADDED? ☐ YES ☐ NO IF YES, HOW MANY?

Print, complete and submit this form by mail, fax or in person to: 14 Weymouth Street, P.O. Box 757, Charlottetown, PE C1A 7L7

Do not email sensitive information. **Fax: 902-368-5696 Tel: 902-368-5680 or 1-800-237-5049**