

**Worker Information**

Last name  First name  Middle initial

Date of Birth  Personal health number  Social insurance number

Address line 1  Address line 2

City  Province/state  Country  Postal code/zip

Home phone  Business phone  Extension

**Employer Information**

Organization name

Type of business  Operating location

Address line 1  Address line 2

City  Province/state  Country  Postal code/zip

Contact name  Phone number  Extension

**Incident Information**

1. Date and time of incident  OR 2. Period of exposure resulting in occupational disease  
 From  To

3. My injury or disease was first reported to my employer  
 on  at  (please specify)  
 TO:  First aid  Supervisor  Office  Other

4. Name of person reported to

5. Did you receive first aid?  
 Yes  No 6. Date of first aid  7. Name of first aid attendant

8. Did you go to the hospital, a medical clinic, or see a physician?  
 Yes  No 9. If yes, name of physician or provider

10. Address of physician or provider

11. Are you aware of any recent pain or disability in the area of your reported injury?  
 Yes  No If yes, please explain

12. Was protective equipment being used?  
 Yes  No 13. Where there any witnesses?  Yes  No 14. The supervisor in charge at the time

**Incident information (continued)**

15. Describe how the incident happened

16. Describe the injury in detail

[Greyed out text area]

17. Side of body injured     Left     Right     Both     N/A

18. Describe the work incident location (address) and where incident occurred (e.g. shop floor, parking lot)

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19. Contributing factors - select AT LEAST ONE, and as many as applicable

- Lifting          lb     kg    Animal bite
- Overexertion     Struck     Assault
- Repetitive     Crush     Motor vehicle accident
- Slip or trip     Sharp edge     Unsure/other (explain below)
- Twist     Fire or explosion
- Fall     Harmful substance in the work environment

20. Did you or will you miss any time from work beyond the date of injury or exposure?

Yes     No

**Signature and report date**

21. Worker signature

22. Date of report

[Yellow signature box]

[Greyed out date box]

**Additional information**

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