Safety Matters @Work

Workers Compensation Board of PEI

EMPLOYER'S REPORT — FORM 7

The Employer's Report may be submitted electronically with a WCB Online Services account. Visit www.wcb.pe.ca

-or-

Print, complete and submit this form by mail, fax or in person to:
14 Weymouth Street, P.O. Box 757, Charlottetown, PE C1A 7L7
Fax: 902-368-5696 Tel: 902-368-5680 or 1-800-237-5049

ALL INFORMATION IN SECTIONS 1 THROUGH 8 MUST BE COMPLETED FULLY

1. Worker Information

☐ Lost Time ☐ No Lost Time ☐ Unknown

Last Name:	First Name:		Initials:
Address:		City:	
Province:	Postal Code:	Home Telephone:	Date of Birth: M D Y
Job Title:	Employee #: *(if applicable)*		Date of Hire: M D Y

2. Employer Information

Employer Firm Name:	Company Telephone:
WCB Firm Number (*Mandatory Field*):	WCB Operation Number:
Address:	Is the worker a partner/director in this business? Y N
City: Postal Code: Province:	Does your firm have 20 or more workers? Y N
Contact Name and Telephone:	

3. Injury or Occupational Disease Information

COMPLETE EITHER **a** or **b** or **c**

a) Please provide date and time of injury or specific incident.

Date: M D Y **Time:** _____ ☐ a.m. ☐ p.m.

b) ☐ The injury developed over a period of time. **c)** ☐ The injury is a recurrence of a prior injury.

4. Report to Employer

Was the injury reported to the employer? ☐ Y ☐ N

If yes, please provide the following: **To Whom:** _____ **Job Title:** _____

Date: M D Y **Time:** _____ ☐ a.m. ☐ p.m.

Did the worker seek medical treatment? ☐ Y ☐ N ☐ Unknown

5. Location of Accident

Did the injury occur in PEI? ☐ Y ☐ N Did the injury occur on the employer's premises? ☐ Y ☐ N

If no, where did it happen? _____

6. Witnesses

Were there witnesses? ☐ Y ☐ N

Name:	Telephone:
Name:	Telephone:

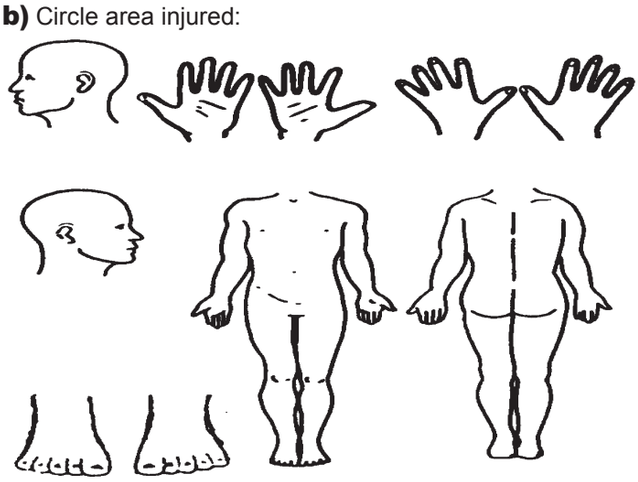
7. Previous Pain or Injury

Do you know of any previous pain or injury in the area of the worker's present injury? ☐ Y ☐ N
If yes, please explain:

8. Part of Body

a) Body Part Injured: _____

b) Circle area injured:



9. Accident Description

a) Describe fully what happened:
(If necessary, use a separate sheet)

b) Do you have any issues or concerns? ☐ Y ☐ N
If yes, please explain:

Please complete the other side — Submit Promptly

COMPLETE SECTIONS 10 THROUGH 14 ONLY IF THE WORKER HAS MISSED TIME FROM WORK

10. Type of Employment

a) ☐ Full Time ☐ Part Time ☐ Other Please Specify: _____

b) ☐ Permanent ☐ Seasonal ☐ Temporary ☐ Other Please Specify: _____

Had the injury not occurred, what would be the worker's last day of work? M D Y

c) Is the worker employed as: ☐ Contractor ☐ Independent Operator ☐ Apprentice ☐ Not Applicable

11. Wage Information — COMPLETE EITHER a or b

a) (i) Worker's Rate of Pay: $ _____
☐ Hourly ☐ Monthly
☐ Weekly ☐ Other
☐ Bi-Weekly

(ii) Vacation Pay: % _____
☐ Taken as paid time off
☐ Included in regular wages
☐ Other

(iii) Regular Overtime: $ _____
☐ Hourly ☐ Other
☐ Weekly ☐ N/A
☐ Bi-Weekly

b) Gross Earnings: ☐ Last 12 Months $ _____ From: M D Y To: M D Y

OR Gross Earnings: ☐ Last Tax Year $ _____ Year:

12. Hours of Work — COMPLETE EITHER a or b

a) Usual hours worked per day: _____ Usual number of days worked per week: _____

b) Average hours per week for shift workers: _____

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Wk 1 - Hours per day							
Wk 2 - Hours per day							
Wk 3 - Hours per day							

Circle day of injury

Does the work schedule repeat? ☐ Y ☐ N

Contact name for payroll information: Telephone Number:

13. Lost Time / Return to Work Information

Date worker first missed work: M D Y

SIN:

Has the worker returned to work? ☐ Y ☐ N If yes, please provide the date: M D Y

Has the worker continued to receive regular pay? ☐ Y ☐ N

14. Return to Work Planning

Do you have a Return to Work program? ☐ Y ☐ N Can you accommodate an easeback? ☐ Y ☐ N

Are modified/alternative duties available? ☐ Y ☐ N

Contact Name for Return to Work Planning: Telephone Number:

Re-employment Obligation:

A re-employment obligation may exist if there are 20 or more workers in your employment and if, at the date of injury, you have employed the injured worker for at least 12 continuous months.

Please Note:

If you have concerns with this claim, please contact the Workers Compensation Board of PEI to discuss your concerns or you may submit a letter detailing your concerns. An Employer Advisor is available to provide advice and/or clarification on a WCB claim related to your firm. The Employer Advisor operates independently of the Workers Compensation Board and can be reached at 902-368-6132.

Your opinion is important to us. To improve services, the WCB may contract an independent survey company to survey a sample of employers. The WCB does not know which employers will be contacted. If you are contacted, we encourage you to participate. The research company does not share your personal responses with the WCB.

Declaration: I certify that the information given on this form is true. I agree to notify the Workers Compensation Board of PEI immediately of any change in circumstances affecting this claim, including any return to work. I understand that the Workers Compensation Act requires employers to submit a report within three days of notification or awareness of an injury or occupational disease requiring treatment or an absence from work. I am aware that penalties may be levied for late filing.

Note: Where applicable, the employer information on this form is collected under the authority of subsection 59(3) of the Workers Compensation Act and will be used for the purpose of identifying the accident employer and for monitoring workplace safety.

Name of person completing this form (print): Job Title:

Signature: Date:

Are there extra pages added? YES ☐ NO ☐ If yes, how many? _____