



# Employer's Report Form 7

## User Guide

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WCB Information Series publication

The purpose of this *User Guide* is to assist employers in completing the *Employer's Report Form 7*.

At any time, if you have questions or comments, we encourage you to contact us. Your timely participation in this process is important in making claim related decisions.

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Copies of the forms are available  
on our Web site.

Web site: [www.wcb.pe.ca](http://www.wcb.pe.ca)

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## ***What injuries should you report to WCB?***

- An Employer's Report Form 7, must be submitted for all work-related accidents resulting in the need for medical attention regardless of lost time or no lost time.
- This includes injuries or illnesses that occurred over a period of time, as well as those caused by a single event.

An Employer's Report Form 7, is also required for all accidents resulting in death.

- Report all serious workplace injuries (as defined under section 36(1) of the Occupational Health and Safety Act) within 24 hrs to WCB at 902-628-7513.

## ***How soon should you submit the report to WCB?***

- The Report must be submitted to the WCB within three (3) days of the employer being notified of a workplace injury or occupational disease.
- If the WCB does not receive the report in this time period, a penalty may be applied.

## ***What if I have additional information or concerns?***

- Attach a letter detailing any additional information that would help the WCB make a decision about the claim. Include names, telephone numbers, and statements of any witnesses if possible.
- Call the WCB, ask to speak to an Entitlement Officer and advise them of your concerns.

## COMPLETING THE FORM 7

Please refer to the instructions on these pages for help in completing your *Employer's Report Form 7*. The numbers refer to the question numbers on the form.

### (1) WORKER INFORMATION

Completing this section provides the WCB with information so the worker is easily identifiable. Please attempt to complete all fields in this section.

Please select "Lost Time" if worker has lost time from work, select "No Lost Time" if worker has not lost time from work, or select "unknown" if you are unaware of the worker having missed time.

### (2) EMPLOYER INFORMATION

Completing this section provides information so the employer is easily identifiable. Please attempt to complete all fields in this section.

Ensure your Employer Firm Number and Employer Operation Number are recorded. If you are unsure of your number, it can be found on your monthly statement or by contacting the phone numbers provided in this document.

If the worker is a Partner or Director in the business, check the "yes" box. These workers may not be covered by Workers Compensation unless optional coverage or personal coverage has been purchased separately.

If you have 20 or more workers select "yes", if not select "no". A re-employment obligation may exist if there are 20 or more workers in your employment.

The contact name is the name of the person WCB contacts to get details of the accident whereas the payroll contact name on the second page is the person WCB will contact to get payroll information.

### (3) INJURY OR OCCUPATIONAL DISEASE INFORMATION

The WCB must determine if the worker's injury or illness resulted from a single event (e.g., a fall) or developed over a period of time (e.g., carpal tunnel).

Complete either a or b or c.

a) If the injury happened from a single event, provide the date and time of the accident and the worker's scheduled hours for the shift.

b) If the injury developed over a period of time, check the box next to "the injury developed over a period of time".

c) If the injury is a recurrence of a prior injury, check the box next to "this injury is a recurrence of a prior injury".

### (4) REPORT TO EMPLOYER

Check the yes or no box indicating if the injury was reported to the employer.

If yes, enter the name and job title of the person within the organization to whom the accident was reported.

Enter the date and time the injury was reported to this individual.

### (5) LOCATION OF ACCIDENT

Check the yes or no box indicating whether or not the injury occurred on the employer's premises. If no, enter the location of the accident (e.g., training facility, highway accident).

### (6) WITNESSES

Check the yes or no box indicating if there were witnesses. If yes, provide the name, job title and telephone number where the individual(s) may be reached.

Not all witnesses are contacted. The individual circumstances of the claim will determine if a call is made.

## (7) PREVIOUS PAIN OR INJURY

Check the yes or no box indicating if there was or was not previous pain in the same body area. This information is used in the adjudication of the claim. A previous history does not necessarily prevent a worker from entitlement to benefits.

## (8) PART OF BODY

In section 8a, indicate the part of the body that was injured (e.g., left arm). If the injury is to the back, indicate whether it is for the upper, middle or lower part of the back.

In section 8b, circle the body part on the chart.

## (9) ACCIDENT DESCRIPTION

The WCB must have details about the injury and accident to ensure that a claim is work-related and to determine the severity of the injury.

Provide a detailed description of how the accident happened, including what the worker was doing just before the injury/illness occurred. Also, note any other people or factors (e.g., vehicles, equipment, etc.) involved in the accident.

### Example #1:

(Progressive – Over time)

“Joe is employed as part of a paving crew. He uses a power jack to break up pavement. As a result of the continuous vibration of the jack, Joe is having pain in his wrist which is increasing with time.”

### Example #2:

(Acute – Single Event)

“Sally works in the display department and is responsible for decorating the store front windows. She was backing down a six foot step ladder, slipped, and fell 4 rungs to the floor. She has a broken right ankle.”

If the accident was not reported, write “unaware of an accident” in this section.

Complete Sections 10 – 13 only if worker has lost time from work.

## (10) LOST TIME/RETURN TO WORK INFORMATION

Enter the date the worker first missed work due to the injury.

WCB uses the worker's Social Insurance Number (SIN) to provide income tax statements to workers who receive wage loss benefits from the WCB.

Enter the date the worker first returned to work after the injury. If unknown, leave it blank.

If the worker has returned to work, indicate if the worker returned to regular duties or if you have provided modified duties for the worker.

If the worker has not returned to work please indicate if modified duties are available.

## (11) TYPE OF EMPLOYMENT

Complete all sections

If the worker is a seasonal or temporary worker, enter the last day the worker is expected to work for this season. If the date is not known, enter the approximate time frame (i.e., usually laid off in November)

## (12) WAGE INFORMATION

Complete either a or b.

a) If the worker has a “regular” rate of pay, hourly, weekly, etc., complete this section.

Please indicate the % of Vacation pay the worker earns, and whether it is paid on a regular basis (i.e., Added to each pay cheque) or if it is taken as paid time off.

Also, please indicate if over time is paid on a regular basis, and if so please indicate how much the worker earns in overtime, and how often this is paid. If not applicable select N/A.

b) If the worker does not have regular earnings or regular work hours, and it may be easier to provide the gross earnings for a given time period, complete this section.

### **(13) HOURS OF WORK**

Complete either a or b.

a) If the worker is normally scheduled for the same number of days and hours per week, complete this section.

b) If the worker works shift work, enter the average number of hours worked per week. Also using the table provided, enter the shifts for the two weeks prior to the injury and the shifts for the week of the injury.

Please record the name and telephone number of the contact person for questions regarding payroll.

## ***DID YOU KNOW?***

- There is a wait period. The worker is not compensated for wage loss benefits on the day of the accident. Sixty (60) percent of the first week of wage loss is withheld.
- All decisions may be appealed. You have ninety (90) days from the date of the decision to file an appeal to the Internal Reconsideration Officer.
- There is an Employer Advisor who can help you with any questions you may have regarding Workers Compensation. The Employer Advisor can be reached at 902-368-6132.
- Following a worker's recovery, all employers are required to provide suitable work that is available and consistent with the worker's functional abilities and that, where possible, restores the worker's pre-injury earnings.

For further information,  
please visit on our website [www.wcb.pe.ca](http://www.wcb.pe.ca)  
under the link publications.





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