WSCC Workers' Safety & Compensation Commission | ᐃᖅᑲᓇᐃᔭᖅᑎᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪ ᓇᓐᓂᐅᒃᑯᒫᓂᒃ ᖃᐅᔨᓴᖅᑎᑦ

Harvester's Report of Incident

COMPLETE ALL QUESTIONS, SIGN AND SEND TO THE WSCC AT THE ADDRESS ON REVERSE - PLEASE PRINT CLEARLY

WSCC Claim Number

Harvester's *last name*	*first name*	Marital Status
Postal address - *include postal code*		Dependents
Telephone - *include area code*		Sex ❑ M ❑ F
Social Insurance Number	General Hunting License Number	
Date of Birth YY MM DD	Preferred Language	

1. a) Incident Date YY MM DD Time: ____________ ❑ AM ❑ PM

   b) Did you have to stop harvesting after your incident? If yes, when YY MM DD ❑ AM ❑ PM

   c) When did you go to the doctor or nurse? YY MM DD ❑ AM ❑ PM

   d) If you did not get medical treatment immediately, give reason

   ____

   e) Where did the incident happen?

2. How did the incident happen and what injury did you receive? Be specific (i.e. lifting, or, if you fell, how far did you fall? State right or left, if applicable). Attach extra sheet(s) if necessary.

Mark Injured Part

Right Left Left Right

____
____
____
____
____
____
____
____
____

3. **IMPORTANT - LIST ANY WITNESSES**

Name and postal address - *include postal code*	Name and postal address - *include postal code*

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND SEND IMMEDIATELY TO WSCC

Harvester's Name: ______________________

4. a) Name of doctor or nurse

   b) Which hospital or nursing station did you go to, if any? When? | YY | MM | DD |

   c) If your teeth were injured, give name of dentist

5. a) Have you had a similar disability before? ❏ Yes ❏ No If yes - explain

   b) Have you had previous claims with the WSCC? ❏ Yes ❏ No If yes - give dates and nature of injury

6. a) Are you back at harvesting activities? ❏ Yes ❏ No If yes - give date you returned to harvesting

   b) If no, when do you think you will be able to return to harvesting? Provide the date you should be able to return | YY | MM | DD |

   c) If you harvested since you were hurt provide the dates you harvested From | YY | MM | DD | To | YY | MM | DD |

7. In the twelve months before the incident, what other employment earning or income did you receive?

Name of Company	From YY	MM	DD	To YY	MM	DD	Total Earnings
Name of Company							
Name of Company							
Name of Company							

8. Amount of income from harvested renewable resources (i.e. sales of wild meat, fish, fur sales, etc.)
   From | YY | MM | DD | To | YY | MM | DD | Total Earnings

9. Additional information or comments

WORKER'S CONSENT

I hereby claim compensation for work-related injuries or disease.

Information Sharing- I understand that the above information about me will be used by the WSCC for the sole purpose of conducting an investigation into this claim. I also understand that the WSCC will need to gather more information about my work incident and medical and work history to administer my claim. For that specific purpose only, some personal information may have to be disclosed to employers, medical personnel and other relevant third parties. **I authorize the WSCC to provide and gather such information from all necessary sources, including hospital and doctors' records, and employer records.**

Information Accuracy- I understand that incomplete information from me may delay my claim, and that untrue information from me is unlawful.

I declare the information above is true and accurate. I understand it may be a criminal offence to make a false claim, or to work and earn income while receiving workers' compensation without telling the WSCC.

Signed at ______________ Date ______________ Signature ______________

Any personal information, as defined by the *Access to Information and Protection of Privacy Act* (ATIP), requested herein is for the purpose of administering the *Workers' Compensation Act* and is authorized by the Act.

For more information, please contact the WSCC ATIP Co-ordinator at 1-800-661-0792 or 1-867-920-3888.

For more information on our Legislation and Policies, please visit our Website
www.wcb.nt.ca • www.wcbnunavut.ca

If you would like assistance filling in this form, or more information, please contact one of our offices listed below

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677
or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407• Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501
Webpage • **www.wcb.nt.ca** or **www.wcbnunavut.ca**

Ce formulaire est disponible en français.
ᑖᒃᑯᐊ ᐊᑐᐃᓐᓇᖅᑐᑦ ᑎᑎᕋᖅᕕᒃᓴᐃᑦ ᐃᓄᒃᑎᑑᖅᓯᒪᓗᑎᒃ.