WSCC Workers' Safety & Compensation Commission | ᐃᖅᑲᓇᐃᔭᖅᑎᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪ ᓇᓪᓕᐅᒃᑯᒫᓂᒃ ᖃᐅᔨᓴᖅᑏᑦ

Employer's Report of Incident

The WSCC may use this information for the administration of legislation under our authority, including the *Workers' Compensation Acts* (WCA), the *Safety Acts*, and/or the *Mine Health and Safety Acts*, and their associated *Regulations*, and to contact you in relation to the requirements under the relevant legislation. It is your responsibility when providing an email address to ensure reasonable safeguards are in place to protect the confidentiality and security of your personal information within your email account.

Attention: If you are only reporting a dangerous occurrence, only complete page 1 of this report.

If you need assistance filling in this form, or more information, contact us.
NWT Toll Free: 1-800-661-0792 • Nunavut Toll Free: 1-877-404-4407

Employers must submit this fully completed incident report within three business days. See page 4 for penalties as listed in the WCA.

A – Employer Information

Business Name	Contact Person	WSCC Account #	Supervisor's Name

Mailing Address	Community	Territory/Province	Postal Code

Phone Number	Fax Number	Email Address

B – Type of Occurrence *(Refer to page 5 for definitions of dangerous occurrences and accidents causing serious bodily injury.)*

Answer **ALL** of the following questions.

Are you reporting:

NOTE: To report an **accident causing serious bodily injury** or a **dangerous occurrence**, you must call the 24-hour Incident Reporting line at 1-800-661-0792 as soon as is reasonably possible *and* complete and submit this form within three business days.

- an **injury**, **illness**, or **exposure**? ☐ Yes ☐ No
- a **dangerous occurrence** as defined in section 1 of the *Occupational Health and Safety Regulations*? ☐ Yes ☐ No
- an **accident causing serious bodily injury** as defined in section 1 of the *Occupational Health and Safety Regulations*? ☐ Yes ☐ No
- a **dangerous occurrence** as defined in section 16.01 of the *Mine Health and Safety Regulations*? ☐ Yes ☐ No
- a **reportable incident** involving serious injury or death as defined in section 16.01 of the *Mine Health and Safety Regulations*? ☐ Yes ☐ No

C – Persons Involved

(Fill in a separate report for each injured worker. If this report is for a dangerous occurrence, as defined in section 1 of the Occupational Health and Safety Regulations, also include the name of each employer, principal contractor, and owner at the worksite.)

First Name	Last Name	Job Title	Injured?
			☐ Yes ☐ No
First Name	Last Name	Job Title	Injured? ☐ Yes ☐ No
First Name	Last Name	Job Title	Injured? ☐ Yes ☐ No

D – Place, Date, and Time of Incident

City	Territory/Province	Worksite
Date of Incident (mm/dd/yy)	Time of Incident (am/pm)	Date and Time First Reported to Employer

E – Incident Details

Describe incident in as much detail as possible. Include where it took place, what the worker was doing, what equipment was being used, and whether the incident involved gas, chemicals, or extreme temperatures (*attach extra page if more room is needed*). **Also state which part(s) of the body was injured.**

F – Injured Worker Information

First Name		Last Name	
Mailing Address	Community	Territory/Province	Postal Code
Residential Address (if different than above)		Date of Birth (mm/dd/yy)	Gender ☐ Male ☐ Female ☐ X
Telephone (include Area Code)	Cell (include Area Code)	Email Address	
Social Insurance Number	Job Title (no abbreviations)		

1. Does the worker work in more than one territory/province for your organization? ☐ Yes ☐ No
   If yes, list the territories/provinces:

2. Was the injury or incident caused by a person(s) not employed by the employer? ☐ Yes ☐ No (*If yes, attach an explanation and contact info.*)

3. Are you disputing this claim? ☐ Yes ☐ No (*If yes, attach an explanation.*)

4. Were the worker's actions at the time of injury for the purpose of your business? ☐ Yes ☐ No (*If no, attach an explanation.*)
   If yes, is the activity part of the worker's regular work? ☐ Yes ☐ No (*If no, attach an explanation.*)

5. Was First Aid given at the worksite? ☐ Yes ☐ No
   (*If yes, attach a copy of the First Aid report.*)
   First Aid Provider's name:

6. Did the worker seek medical attention beyond the worksite? ☐ Yes ☐ No
   (*If yes, where?* ____________ *When?* ____________)

G – Return to Work *(Give full explanations and attach extra sheets if necessary.)*

7. Did the worker stop working? ☐ Yes ☐ No

When? ____________ (mm/dd/yy) Time: ________ ☐ AM ☐ PM

Has the worker returned to work? ☐ Yes → When? ____________ (mm/dd/yy) Time: ________ ☐ AM ☐ PM

☐ No → Has the worker been offered alternate/modified duties? ☐ Yes ☐ No

What is the worker's current status?
- ☐ Returned to pre-injury job with no changes.
- ☐ Returned to pre-injury job with duties changed.
- ☐ Returned to pre-injury job with hours changed.
- ☐ Returned to pre-injury job with duties and hours changed.
- ☐ Returned to work in a different job to accommodate injury.
- ☐ Other accommodations, specify:

8. Did you complete a Return to Work plan for this worker? ☐ Yes ☐ No (*Attach plan or forward within five days.*)
   If you would like assistance completing a Return to Work plan, call 1-800-661-0792 and ask for the Return to Work Specialist.

H – Employment Category

9. Is the worker a subcontractor? ☐ Yes ☐ No
   If yes, who is the contractor?

10. Is the worker an owner or operator? ☐ Yes ☐ No

11. Worker's Type of Employment (*Check all that apply.*)

Permanent
- ☐ Term (Over 1 year)
- ☐ Full / Part-time Permanent
- ☐ Apprentice
- ☐ Relief
- ☐ Other

Non-permanent
- ☐ Term (Under 1 year)
  Term Start Date: ____________ (mm/dd/yy)
  Term End Date: ____________ (mm/dd/yy)
- ☐ Summer Student
- ☐ Casual
- ☐ Apprentice
- ☐ Seasonal
  Start Date: ____________ (mm/dd/yy)
  End Date: ____________ (mm/dd/yy)

12. Is the job subject to seasonal layoffs? ☐ Yes ☐ No

13. Is the job subject to lack of work layoffs? ☐ Yes ☐ No

14. Worker's day of hire (mm/dd/yy)

Worker's Full Name:

I – Schedule Information

15. Number of days on ____________

Number of days off ____________

16. Regular hours per day ____________

17. Regular hours per rotation ____________

18. Indicate days on for one full rotation. Place the number of hours scheduled below for each day worked. i.e. 8am-5pm; 7am-3pm, etc.

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Week 1 - Hours per day							
Week 2 - Hours per day							
Week 3 - Hours per day							
Week 4 - Hours per day							

19. Date rotation started (mm/dd/yy)

Date rotation ended (mm/dd/yy)

20. Are travel days included in the on/off work rotation? ☐ Yes ☐ No

21. How many hours are paid for on travel days? ____________

J – Wage Information (*Complete all questions.*)

22. What is the hourly rate of pay? ____________ / hour. What are the annual gross earnings? ____________

What is the overtime rate? ____________ / hour.

If the worker is paid other than hourly or on salary, explain below in question 30. (*i.e. worker is paid on commission, etc.*)

23. Does the worker regularly work or get paid for overtime? ☐ Yes ☐ No

If yes, how many hours per day are overtime? ____________

Provide an estimate of regular overtime hours ____________ / ☐ day ☐ week ☐ month

24. What percent of vacation pay does the worker receive? ____________ %

Is vacation pay paid on each cheque? ☐ Yes ☐ No

Is vacation pay paid out once a year? ☐ Yes ☐ No When: ____________

Does the worker receive any other benefits? (*Northern Allowance, Bonus, etc.*) ☐ Yes ☐ No

If yes, explain in detail with amounts and averages:

Are these benefits paid out to the worker with their regular pay cheque? ☐ Yes ☐ No

25. Are you paying the worker for lost time? ☐ Yes ☐ No If yes, provide the dates lost time will be paid ____________

26. Will you continue to pay benefits? (*i.e. Northern Allowance*) ☐ Yes ☐ No

27. Wage and Schedule Contact Person:

28. Phone Number:

29. Email Address:

30. Provide any additional wage and schedule information here:

Worker's Full Name:

Provide any additional information here:

Completed by (print)	Phone Number	Date (mm/dd/yy)

It is your responsibility to provide a copy of the Employer's Report of Incident form to your worker.

ATTENTION:
An employer who does not submit a fully completed incident report within three business days, as required by the *Workers' Compensation Acts* (WCA), faces the following penalties:

- **$250 for each of the first two occurrences;**
- **$500 for each of the next two occurrences; and**
- **$1000 for each additional occurrence.**

Submit completed form to the appropriate WSCC office using the contact information 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 • Email: reportsnwt@wscc.nt.ca
or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8501
Toll Free Fax: 1-866-979-8501 • Email: reportsnu@wscc.nu.ca

wscc.nt.ca • wscc.nu.ca

Ce formulaire est disponible en français
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NORTHWEST TERRITORIES AND NUNAVUT
SAFETY ACT
OCCUPATIONAL HEALTH AND SAFETY REGULATIONS
INTERPRETATION

1. In these regulations,

“accident causing serious bodily injury” means an accident at a work site that

(a) causes or could reasonably be expected to cause the death of an individual, or
(b) requires an individual to be admitted to a hospital as an in-patient for a period of 24 hours or more; (*accident causant des lésions corporelles graves*)

“dangerous occurrence” means an occurrence that does not result in, but could have resulted in an accident causing serious bodily injury, such as

(a) structural failure or collapse of
  (i) a structure, scaffold, temporary falsework or concrete formwork, or
  (ii) a tunnel, caisson, coffer dam, trench, excavated shaft or excavation,
(b) failure of a crane or hoist or the overturning of a crane or powered mobile equipment,
(c) accidental contact with an energized conductor,
(d) bursting of a grinding wheel,
(e) uncontrolled spill or escape of a toxic, corrosive or explosive substance,
(f) premature or accidental detonation of explosives,
(g) failure of an elevated or suspended platform, or
(h) failure of an atmosphere-supplying respirator; (*événement dangereux*)

NORTHWEST TERRITORIES AND NUNAVUT
MINE HEALTH AND SAFETY REGULATIONS
PART XVI

16.01. In this part,

“dangerous occurrence” means

(a) an incident involving the hoist, sheaves, hoisting rope, conveyance or shaft timbering or structure,
(b) an inrush of water,
(c) a cracking, seeping, or failure of a dam or bulkhead,
(d) an outbreak of fire,
(e) a premature or unexpected explosion or ignition,
(f) the occurrence of flammable, noxious or toxic gas in mine workings or at an exploration site,
(g) unexpected and non-controlled extensive subsidence or caving of mine workings,
(h) an explosion or outbreak of fire in any way related to the operation of an air compressor, air receiver, compressed air line or steam boiler,
(i) a breakdown in the main ventilation system,
(j) loss of control or major damage to any mobile equipment,
(k) an uncontrolled fall of ground causing physical damage or the displacement of more than 50 t of material, and
(l) any unusual occurrence not listed in paragraphs (a) to (k); (*événement dangereux*)

“reportable incident” is an incident involving serious injury or death; (*incident à signaler*)

“serious injury” includes:

(a) a fracture of the skull, spine, pelvis, femur, humerus, fibula, tibia, radius or ulna,
(b) an amputation of a major part of a hand or foot,
(c) the permanent loss of the sight of an eye,
(d) any serious internal haemorrhage,
(e) any burn that is caused by electricity and requires medical attention,
(f) any third degree burn,
(g) any injury caused directly or indirectly by explosives,
(h) any asphyxiation or poisoning that causes a partial or total loss of physical control, and
(i) any other injury likely to endanger life or cause permanent impairment. (*blessure grave*)