WSCC Workers' Safety & Compensation Commission

Worker's Continuity Report

RETURN THIS FORM FULLY COMPLETED FOR CONSIDERATION OF FURTHER ENTITLEMENT OF THIS CLAIM.

Claim Information

WSCC Claim Number:	Original Date of Injury:
Injury Type:	

Worker Information

First Name:	Last Name:
Mailing Address (include postal code):	
Residential Address:	
Telephone (include area code):	

Employer Information

Business Name:
Mailing Address (include postal code):
Telephone (include area code):

Your address, postal code and telephone number, if different from above:	Your current employer's name, address, postal code and telephone number, if different from above.

Describe your condition since your claim was last active.

Dates and nature of medical treatment received since the original injury.	Name, address and telephone number of the attending physician.

IF YOU PURCHASED PRESCRIPTIONS RELATED TO THE ORIGINAL INJURY, PLEASE PROVIDE THE FOLLOWING:	
Name, address and telephone number of physician	**Name of prescription and dates purchased**
Name:	Name: Date: YYYY MM DD
Address:	Name: Date: YYYY MM DD
Postal Code:	Name: Date: YYYY MM DD
Telephone (include area code):	Name: Date: YYYY MM DD

If fellow workers or supervisors are aware of your continuing problems, provide their names and addresses.		
Name:	Name:	Name:
Address:	Address:	Address:
Postal Code:	Postal Code:	Postal Code:

If a further incident aggravated your disability, give details.

Why do you feel your current condition is the result of this incident?

Provide any additional facts that may be helpful in establishing further entitlement.

If you stopped work due to your disability, please provide dates.

WORKER'S CONSENT

Information Sharing – I understand the WSCC uses the above information about me for the sole purpose of conducting an investigation into this claim. I also understand 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, the WSCC may disclose some personal information 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 incomplete information from me may delay my claim, and 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.

Name: ______________________ Date: ______________________

Witness: ______________________ Date: ______________________

Yellowknife: 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
Iqaluit: 2A-630 Queen Elizabeth Way, Iqaluit, NU X0A 3H0 • 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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