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

Worker's Report of Injury

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

IF A QUESTION DOES NOT APPLY, INDICATE WITH "N/A".

A – Worker Information

First Name	Last Name	Also Known As	
Mailing Address	Community	Territory/Province	Postal Code
Residential Address (if different than above)		Date of Birth M M D D Y Y	Gender ☐ Male ☐ Female ☐ X
Telephone (include Area Code)	Cell (include Area Code)	Email Address	
Social Insurance Number	Preferred Language ☐ English ☐ French ☐ Inuktitut ☐ Other _____		
Job Title (no abbreviations)			

B – Employer Information

Employer Name	Address
Supervisor Name	Telephone (include Area Code)
Do you work for this employer in a province or territory other than the Northwest Territories or Nunavut? ☐ Yes ☐ No If yes, where?	

The WSCC may use this information for the administration of legislation under our authority, including the *Workers' Compensation Acts,* 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.

The WSCC may only use my personal information, as provided here for the sole purpose of conducting an investigation for my compensation claim. The WSCC may gather more information on my work incident and medical and work history to administer my claim for compensation. For that purpose only, the WSCC may disclose some personal information to my employer, medical personnel, and other relevant third parties. For more information please read our ***Privacy Statement for Workers*** *at wscc.nt.ca or wscc.nu.ca.*

Having read the requirements above, **I understand and authorize the WSCC to collect and provide such information from all necessary sources.**

Initial Print to initial Part of the body injured _____ Injury date: M M D D Y Y

I understand and acknowledge that incomplete information from me may delay my claim.
It may be a criminal offence to work and earn income while receiving workers' compensation benefits without the WSCC's approval.

Signature: _____ Please print form to sign _____ Date: M M D D Y Y

Witness: _____ Please print form to sign _____ Date: M M D D Y Y

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.

PLEASE PROCEED TO 2ND PAGE. →

Worker's Full Name:

C – Incident Details

1. Date of Incident M M D D Y Y Time: _____ ☐ AM ☐ PM

2. Place of Incident
Community: _____ Territory/Province: _____

3. Did you delay reporting for more than one day? ☐ Yes ☐ No If yes, why? (Please explain)

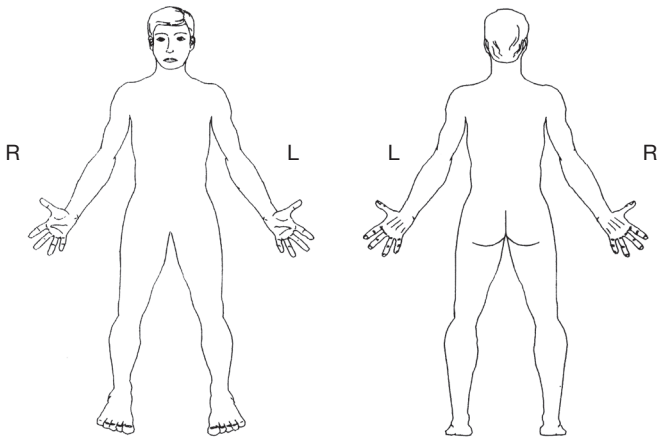
4. Did incident occur on employer's premises? ☐ Yes ☐ No If no, where did the incident occur?

5. Name and position of person you reported incident to:
Name: _____ Position: _____ Phone: ___ ___ ____

6. Did you stop working due to your injury? ☐ Yes ☐ No If yes, when? M M D D Y Y Time: _____ ☐ AM ☐ PM

IMPORTANT

7. Please describe the incident in as much detail as possible.
Include: what you were doing; where the injury took place; what equipment you were using; and, whether the incident involved gas, chemicals or extreme temperatures *(Please use attached sheet if necessary).*



What body parts did you injure? (left/right side, hand, eye, back, etc.)
Please also indicate the body parts on the diagram.

What type of injuries? (sprain, bruise, fracture, etc.)

8. **IMPORTANT - Please list any witnesses.**

Name	Address	Contact Number
Name	Address	Contact Number

9. Did you seek medical attention? ☐ Yes ☐ No When? M M D D Y Y

10. Where did you receive medical attention? When? M M D D Y Y Time: _____ ☐ AM ☐ PM

11. If medical attention was given by First Aid or Medical Aid, please provide contact information.

First Aid:	Name	Phone	Email
Medical Aid:	Facility Name		

PLEASE PROCEED TO 3RD PAGE. →

Worker's Full Name:

D – Past Injuries

12. Have you previously injured or experienced ongoing pain in the same body part? ☐ Yes ☐ No
    If yes, please explain. Include dates if possible.

13. Do you have any previous compensation claims with the WSCC, or any other workers' compensation board? ☐ Yes ☐ No
    If yes, provide dates and nature of injury.

E – Return to Work

14. Did your employer offer you modified or alternative work? ☐ Yes ☐ No
    If yes, what are the modified duties?
    When? M M D D Y Y

15. Did you return to work? ☐ Yes ☐ No If yes, ☐ Light Duties ☐ Regular Duties
    If no, when do you expect to return to work (e.g., a month, 2 days, etc.) _____
    When? M M D D Y Y

F – Employment

16. Worker's Type of Employment

Permanent

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

Non-permanent

- ☐ Term (Under 1 year) -
  Term End Date: M M D D Y Y
- ☐ Summer Student
- ☐ Casual
- ☐ Apprentice
- ☐ Seasonal -
  Start Date: M M D D Y Y
  End Date: M M D D Y Y

G – Schedule Information

17. Number of days on _____
    Number of days off _____

18. Regular hours per day _____

19. Regular hours per rotation _____

H – Wage Information (Please complete all questions.)

20. What is your hourly rate of pay? _____ / hour. What are your annual gross earnings? _____

21. Do you regularly work overtime? ☐ Yes ☐ No
    If yes, how many hours per day are overtime? _____ Provide an estimate of regular overtime hours _____ / ☐ day ☐ week ☐ month

22. Do you receive any other earnings? Please check all that apply.
    ☐ Vacation pay ☐ Uniform allowances ☐ Northern living allowance
    ☐ Other: (please specify) _____

23. Do you have a second job? ☐ Yes ☐ No If yes, did you miss time from this job due to your injury? ☐ Yes ☐ No
    (If you have more than one employer, please list all employers and their contact information.)

    Name of second employer: _____ Contact name: _____
    Contact phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Wage Information (for tax purposes)

24. Marital Status
    ☐ Single ☐ Married ☐ Common Law ☐ Widowed ☐ Divorced

25. Number of Dependants

26. If married or common-law, does your spouse reside in the same territory/province as you? ☐ Yes ☐ No

WORKER'S CONSENT

I claim compensation for my work-related injury or disease and declare the information provided in support of my claim is true and accurate to the best of my knowledge and belief. I acknowledge it may be a criminal offence to make a false claim.

Initial _____ Print to initial

PLEASE PROCEED TO 4TH PAGE. →

Please add any additional information in the space provided.

Name: _____ Signature: Please print form to sign Date: M M D D Y Y

If you need assistance filling in this form, or more information, please contact our Tele-claim services.

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

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Ce formulaire est disponible en français
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