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

Worker's Report of Injury

If you were injured at work:
1. Tell your employer about the incident
2. Tell your employer that you are submitting the incident to the WSCC.
3. Complete this form and submit it to the WSCC.

Note: You do not have to share this form with your employer. It can be submitted directly to the WSCC.

If a question does not apply, indicate with "N/A".

If you need assistance filling in this form or more information, please contact our Claims Processing team.

NWT Toll Free: 1-800-661-0792 • Nunavut Toll Free: 1-877-404-4407

A – Worker Information

First Name	Last Name	Also Known As

Mailing Address	Community	Territory/Province	Postal Code

Residential Address (Your primary home address if different than above)	Date of Birth	MM	DD	YYYY	Gender ☐ Male ☐ Female ☐ X

Telephone (include Area Code)	Cell (include Area Code)	Email Address

Social Insurance Number	Preferred Contact Method	What is your preferred method for receiving formal decisions made on your claim?
	☐ Telephone ☐ Cell ☐ Email	☐ Email ☐ Mail

Preferred Language
☐ English ☐ French ☐ Inuktitut ☐ Other ______________________

Job Title (no abbreviations)

B – Information About Your Employer

Employer Name	Address

Supervisor Name	Phone (include Area Code)

In which territory do you work for this employer? ☐ Northwest Territories ☐ Nunavut ☐ Both

Do you work for the employer in any other province or territory? ☐ 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	Part of the body injured	Injury Date	MM	DD	YYYY
Print to initial					

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 MM DD YYYY

Witness ______ Please print form to sign ______ Date MM DD YYYY

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. Which of the following did your injury/injuries, or exposure result from?

☐ A specific incident ☐ More than one incident If more than one incident, please explain _____

2. Date of Incident (if applicable)	MM	DD	YYYY	Time _____ ☐ AM ☐ PM	3. Place of Incident: Community _____ Territory/Province _____

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

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

6. Name and position of person you reported incident to:

Name _____ Position _____ Phone (include Area Code) _____

7. Did you stop working due to your injury? ☐ Yes ☐ No If yes, when?	MM	DD	YYYY	Time _____ ☐ AM ☐ PM

8. Which best describes the injury you are reporting?

☐ Physical ☐ Repetitive Strain ☐ Psychological ☐ Illness ☐ Exposure

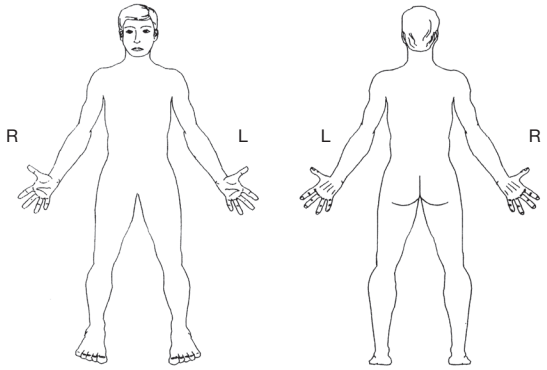
9. How did your injury happen? Please describe the incident that led to your injury in as much detail as possible. (Please use space on last page if necessary)

10. Where in the workplace did the injury happen?

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

12. Describe any equipment, substances (gas/chemicals), extreme temperatures, or other people involved in the incident.

13. Did any person or factor outside your employment cause or contribute to the injury or incident?



14. IMPORTANT – Please list any witnesses.

Name	Address	Phone (include Area Code)
Name	Address	Phone (include Area Code)

15. Did you seek medical attention? ☐ Yes ☐ No

16. Where did you receive medical attention? When?	MM	DD	YYYY	Time _____ ☐ AM ☐ PM

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

First Aid:	Name	Phone (include Area Code)	Email
Medical Aid:	Facility Name		

PLEASE PROCEED TO 3RD PAGE. →

Worker's Full Name:

D – Past Injuries

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

19. 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

A safe and timely return to work helps with recovery and rehabilitation.

20. Have you discussed return to work options with your employer? ☐ Yes ☐ No

21. Did your employer offer you modified or alternative work? ☐ Yes ☐ No When? MM DD YYYY
    If yes, what are the modified duties?

22. Did you return to work? ☐ Yes ☐ No If yes, ☐ Light Duties ☐ Regular Duties When? MM DD YYYY
    If no, when do you expect to return to work (e.g., a month, 2 days, etc.)

23. Have you missed time from work due to this injury? (Note: This does not include missing time on the date the injury occurred) ☐ Yes ☐ No
    If yes, please continue to the next section, **F – Employment**
    If no, please proceed to the last page and complete the **Worker's Acknowledgement** section before submitting your form.

F – Employment

24. What type of employment do you have? ☐ A. Permanent ☐ B. Non-permanent
    Complete employment type "A" or "B" (whichever applies):

    A. Permanent
    ☐ Term (over 1 year) ☐ Full/Part-time Permanent ☐ Apprentice ☐ Relief ☐ Other _____

    B. Non-permanent
    ☐ Term/Contract (under 1 year) – Start Date MM DD YYYY End Date MM DD YYYY

    ☐ Summer Student ☐ Casual ☐ Apprentice ☐ Seasonal – Start Date MM DD YYYY End Date MM DD YYYY

25. Do you work a rotation? ☐ Yes ☐ No
    If no, please explain.

PLEASE PROCEED TO 4TH PAGE. →

Worker's Full Name:

G – Schedule Information

Before your injury/incident, what was your work schedule?

26. Number of days on _____ 27. Regular hours per day _____ 28. Regular hours per rotation _____

Number of days off _____

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

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Week 1							
Week 2							
Week 3							
Week 4							

30. Date rotation started | MM | DD | YYYY | 31. Date rotation ended | MM | DD | YYYY |

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

33. Do you receive a travel allowance? ☐ Yes ☐ No

If yes, how much? $ _____ per day, or $ _____ per hour.

H – Wage Information (Please complete all questions and attach 3 recent pay stubs.)

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

35. 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

36. Do you receive any other earnings or benefits? Please check all that apply.

☐ Vacation pay ☐ Uniform allowances ☐ Northern living allowance ☐ Other (please specify) _____

37. Do you have a second job? Note: Having another position with the same employer is considered 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 email _____ Contact phone (include Area Code) _____

Wage Information (for tax purposes)

38. Marital Status

☐ Single ☐ Married ☐ Common Law ☐ Widowed ☐ Divorced

39. Number of Dependants

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

PLEASE PROCEED TO 5TH PAGE. →

Please add any additional information in the space provided.

Worker's Acknowledgement:

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.

Name: ______________________ Signature: Please print form to sign ______________________ Date: ____ ____ ____
MM DD YYYY

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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