

Worker's Report of Injury, Violence, Or Occupational Disease to Employer

Submit directly to employer (Supervisor). Do NOT submit to WorkSafeBC.

Section 53(3) of the *Workers Compensation Act* requires that, where a worker is fit, and on request of the employer, they must provide the employer with particulars of the injury or occupational disease on a report prescribed by WorkSafeBC and supplied to the worker by the employer. This is the report prescribed.

- Please complete this report as it appears.
- This report should be completed by the injured worker if fit to do so. It can be completed by another individual for signature by the injured worker.
- If you need assistance with completing this form, please see your administrator.

Worker's information

WorkSafeBC claim number (if known) X		Customer care number (if known) X	
Worker's last name X		First name X	Middle initial X
Date of birth (yyyy-mm-dd) - -	Personal health number (BC Services/CareCard) 	Social insurance number 	
Address line 1		Address line 2	
City	Province/State	Country (if not Canada)	Postal code/Zip
Home phone number (include area code)		Business phone number (include area code)	Business extension
Occupation			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Employer's information

Employer's organization name SCHOOL DISTRICT NO. 54 (BULKLEY VALLEY)			
Type of business (if known) EDUCATION		Operating location (if known) SMITHERS/TELKWA/HOUSTON	
Address line 1 BOX 758		Address line 2 1235 MONTREAL STREET	
City SMITHERS	Province/State BC	Country (if not Canada) CANADA	Postal code/Zip V0J 2N0
Employer's contact name ROLANDA LAVALLEE		Employer's phone number (include area code) 250-847-2865	Extension 7005

Incident information

1. Date and time of incident (yyyy-mm-dd) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	OR	2. Period of exposure resulting in occupational disease (yyyy-mm-dd) From To
3. Date and time my injury or disease was first reported to my employer (yyyy-mm-dd) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	My injury or disease was first reported to (please check one) <input type="checkbox"/> First aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Other (specify)	

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Worker's last name X	First name X	Middle initial X	WorkSafeBC claim number X
Social insurance number		Personal health number (BC Services card/CareCard)	

Incident information (continued)

4. Name of person reported To:

Advised or right to seek medical Yes No (If you require medical attention, please do so, and call tele-claim)

5. Did you receive first aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Date of first aid (yyyy-mm-dd)	7. Name of first aid attendant (SD54) X
8. Do you plan, or will you go to the hospital/medical clinic/physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> IF YOU ARE UNDECIDED OR YOU CHANGE YOUR MIND, LET YOUR SUPERVISORS KNOW WHAT YOU DECIDE ASAP.	9. If yes, name of physician or provider (if known) Address of physician or provider (if known)	
11. Are you aware of any recent pain or disability in the area of your reported injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain	
12. Was protective equipment being used Yes <input type="checkbox"/> No <input type="checkbox"/>	13. Were there any witnesses? Yes <input type="checkbox"/> No <input type="checkbox"/> NAME:	

14. The supervisor in charge at the time of my injury was (**Principal/Vice Principal, Manager**)

15. a) If the incident was related to Violence:	15. b) Violence contributing factors	15 c) Violence cont.	15 d) Injury contributing factors
<p>~Was this incident the result of violence? Y <input type="checkbox"/> N <input type="checkbox"/> If No, stop here and go to 15 d). If related to violence, continue and then complete 15b) and c)</p> <ul style="list-style-type: none"> ●Regular Assignment? Y <input type="checkbox"/> N <input type="checkbox"/> ●Are you the victim <input type="checkbox"/> or the witness <input type="checkbox"/>? ●WVIR form used? Y <input type="checkbox"/> N <input type="checkbox"/> ●Was the aggressor(s) involved in any previous violent issues with staff? <input type="checkbox"/> Y <input type="checkbox"/> N ●Reported to health and safety rep ? <input type="checkbox"/> Y <input type="checkbox"/> N <p>_____ (OH&S member reported to)</p> <ul style="list-style-type: none"> ●Was the aggressor (Please check): Student <input type="checkbox"/> Parent <input type="checkbox"/> Public <input type="checkbox"/> Ex-Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Guest <input type="checkbox"/> ●Were the police called? Y <input type="checkbox"/> N <input type="checkbox"/> Police file #: _____ <p>Other Information you think is relevant:</p>	<p><u>If related to violence:</u></p> <p>Threatening <input type="checkbox"/> (specify): _____</p> <p>Scratching <input type="checkbox"/></p> <p>Pushing <input type="checkbox"/></p> <p>Choking <input type="checkbox"/></p> <p>Kicking <input type="checkbox"/></p> <p>Pinching <input type="checkbox"/></p> <p>Hitting <input type="checkbox"/></p> <p>Biting <input type="checkbox"/></p> <p>Head butt <input type="checkbox"/></p> <p>Tripping <input type="checkbox"/></p> <p>Spitting <input type="checkbox"/></p> <p>Struck <input type="checkbox"/></p> <p>Sharp edge <input type="checkbox"/></p> <p>Assault <input type="checkbox"/></p> <p>Stabbing <input type="checkbox"/></p> <p>Tackle <input type="checkbox"/></p> <p>Psychological <input type="checkbox"/> (specify): _____</p>	<p>Throwing objects (specify): _____</p> <p>Weapon (specify): _____</p> <p>Were you working alone? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Were you exposed to blood or bodily fluids Y <input type="checkbox"/> N <input type="checkbox"/> ~ if yes seek medical attention</p> <p>Other (specify): _____</p>	<p>Lifting <input type="checkbox"/> LB _____ KG _____</p> <p>Overexertion <input type="checkbox"/></p> <p>Repetitive (repeated activity) <input type="checkbox"/></p> <p>Slip or trip <input type="checkbox"/></p> <p>Twist <input type="checkbox"/></p> <p>Fall <input type="checkbox"/></p> <p>Struck <input type="checkbox"/></p> <p>Crush <input type="checkbox"/></p> <p>Sharp Edge <input type="checkbox"/></p> <p>Fire or explosion <input type="checkbox"/></p> <p>Harmful substance <input type="checkbox"/></p> <p>Animal bite <input type="checkbox"/></p> <p>Assault <input type="checkbox"/></p> <p>Motor Vehicle accident <input type="checkbox"/></p> <p>Unsure/other <input type="checkbox"/> (please explain): _____</p>

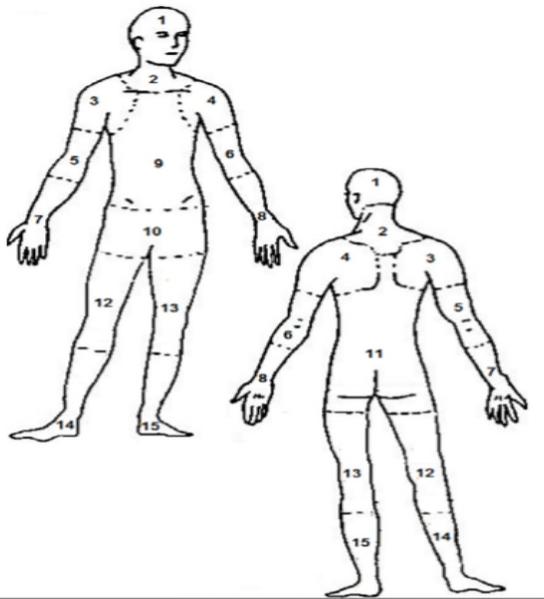
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15 c) Describe in words how the incident happened:

16. Describe the injury in detail (what part of the body was injured) :

INCIDENT INFORMATION

Using the body map, describe any injuries



Body segment

Head or face

Neck

Right shoulder

Left shoulder

Right elbow

Left elbow

Wrist or hand right

Wrist or hand left

Abdomen

Pelvic region

Back

Knee & thigh right

Knee & thigh left

Foot and ankle right

Foot and ankle left

Other (specify):

17. Side of body injured

Left

Right

Both

Not applicable

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Worker's last name X	First name X	Middle initial X	WorkSafeBC claim number X
Social insurance number		Personal health number (BC Services card/CareCard)	

Incident information (continued)

18. Describe the work incident location (address, city, province) and where incident occurred (e.g., classroom, shop floor, lunchroom, parking lot) Please provide **exact location** of the incident including site address and exact location in the building or grounds.

20. Did you or will you miss any time from work beyond the date of injury or exposure?
 Yes No If so, when was the first day missed? (yyyy-mm-dd) _____

Signature and report date

21. Worker's signature	22. Date of report (yyyy-mm-dd)
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Additional information **(****REQUIRED INFORMATION****)**

1.) Please indicate the year you hired on with S54 (yyyy-mm-dd) _____/_____/_____

2.) At the time of injury, were you (check all that apply):

- Permanent
- Temporary
- Full time
- Part time
- Apprentice
- Volunteer
- Student
- New to workforce
- Self-employed
- Relative of employee
- Hired on contract casual
- Other (please specify):

The BC Legislature provides impartial advisers on all workers' compensation matters. The Workers' Advisers Office (WAO) provides free advice and assistance to workers and their dependants on disagreements they may have with WorkSafeBC decisions. WAO operates independently of WorkSafeBC. They have offices throughout the province and can be contacted at www.labour.gov.bc.ca/wab/ or by telephone: Richmond 604.713.0360, toll-free 1.800.663.4261; Victoria 250.952.4393, toll-free 1.800.661.4066; Kelowna 250.717.2096, toll-free 1.800.663.6695.

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.

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