WCB Workers Compensation Board of Manitoba

Phone 204-954-4321
(toll free 1-855-954-4321)
333 Broadway, Winnipeg R3C 4W3
wcb.mb.ca

# Employer's Incident Report

| Claim Number | 2 |
|---|---|

## Employer Information

| Business Name | | | Address (include branch where applicable) | | |
|---|---|---|---|---|---|
| City | Province | Postal Code | Firm Number | Industry Code | Phone Number |

## Worker Information (Please type all dates as dd-mm-yyyy.)

| Last Name | | First Name | |
|---|---|---|---|
| Address | | | City |
| Province | Postal Code | Phone Number | Date of Birth (dd-mm-yyyy) |
| Social Insurance Number | ☐ Male ☐ Female | Job Title | |

## Incident Details

| Date of incident DD/MM/YYYY | Areas of injury |
|---|---|
| Date reported to employer DD/MM/YYYY | Name and position to whom incident was reported |
| Please describe the incident in as much detail as possible. (Use seperate sheet if necessary.) | |
| City and province where incident occured | |
| If the incident occurred out of province, is the worker's usual place of employment in Manitoba? ☐ Yes ☐ No | |
| Had the worker been employed outside of Manitoba for 6 months or longer at the time of the incident? ☐ Yes ☐ No | |
| Did the incident occur on your premises? ☐ Yes ☐ No | If no, specify name and address of premises where incident happened. |

## Name and Address of Doctor(s) and/or Hospital(s) who Provided Treatment (If known)

| Name | Address |
|---|---|
| Name | Address |

## Time Loss and Wages (Only complete this section if the worker missed time from work beyond the date of the incident.)

| What was the last day and hour worked following the incident? ☐ AM ☐ PM | |
|---|---|
| Has the worker returned to work? ☐ Yes ☐ No | If yes, when? ☐ AM ☐ PM |
| Are you continuing to pay the worker during time loss? ☐ Yes ☐ No | What wages were paid to the worker on the last date worked? $ |
| How many hours does the worker work per week? If it varies, please describe. | What are the worker's regular days off? If it varies, please describe. |
| What are the worker's regular gross earnings? (Specify weekly, biweekly, etc.) | What are the worker's total gross earnings for the last calendar year? $ |
| What date did the worker begin employment with your firm? DD/MM/YYYY | If employed less than one year, what are the worker's gross earnings for the period from the date of employment to the date of the incident? |
| If employed more than one year, what are the worker's gross earnings during the twelve months prior to the date of the incident? $ | Are you able to accommodate worker in alternate duties? ☐ Yes ☐ No |

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Fax this form - in Winnipeg: 204-954-4999 | toll free: 1-877-872-3804

| Worker's Name | Claim Number | 2 |
|---|---|---|

## Coverage

| | |
|---|---|
| Was anyone not employed by you involved in the incident? ☐ Yes ☐ No | If yes, give name and address. |

Is the worker a partner, director or sole proprietor of the company? ☐ Yes ☐ No

**Please answer these questions if the incident occurred between Jan. 1, 1992 and Dec. 31, 2005.**

Is the worker a member of the employer's family (or if the employer is a corporation, a family member of a director of the corporation)? ☐ Yes ☐ No

If yes, does the worker reside with the employer or director? ☐ Yes ☐ No

Is the worker a sub-contractor? ☐ Yes ☐ No If yes, specify: ☐ Construction ☐ Logging (Complete appropriate sections below.)

Is the worker an owner operator? ☐ Yes ☐ No If yes, specify: ☐ Courier ☐ Trucking ☐ Towing (Complete appropriate sections below.)

## Farming

Is the worker related to the farm owner? ☐ Yes ☐ No

## Sub-Contractor or Owner Operator (Only complete if worker is a sub-contractor or owner operator.)

| | |
|---|---|
| Are you covering the worker under your WCB coverage? ☐ Yes ☐ No | If no, is the worker registered with WCB? ☐ Yes ☐ No |
| Does the worker work in a partnership? ☐ Yes ☐ No | Does the worker employ other workers? ☐ Yes ☐ No |

### Sub-Contractor in Construction

| | |
|---|---|
| Does the worker supply any materials or equipment? ☐ Yes ☐ No | If yes, please specify. |

### Sub-Contractor in Logging

| | |
|---|---|
| Does the worker supply any materials or equipment? ☐ Yes ☐ No | If yes, please specify. |
| Was the worker cutting on the firm's timber sale, timber permit or sawmill license? ☐ Yes ☐ No | If no, on whose timber sale, timber permit or sawmill license was the worker cutting? |

### Owner Operator is a Courier

What is the gross vehicle weight? (This can be obtained from the Autopac registration.)

### Owner Operator in Trucking

| | |
|---|---|
| Does the worker haul within a 16 km radius of the city or town in which the home terminal is located? ☐ Yes ☐ No | Is the worker a long distance driver? ☐ Yes ☐ No |
| Does the worker provide a vehicle? ☐ Yes ☐ No | If yes, how many vehicles? |

| Name and Position of Person Completing Report | Date (mm-dd-yyyy) |
|---|---|