Saskatchewan Workers' Compensation Board
200-1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com
Phone: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free fax: 1.888.844.7773

E1

Click on any field to start editing.

Reset Form

Employer's Initial Report of Injury

WCB claim number:

Reporting options: 1) Phone: 1.800.787.9288 2) www.wcbsask.com 3) Fax

Section A: Employer Information

Company name: Advanced Education and Employment

Address: 12th Floor, 1945 Hamilton St

City: Regina Prov: SK Postal code: S4P 2C8

Type of business:
Phone: Fax:
Contact person:
Email:
WCB firm number: 0300063C Industry rate code: G5101

Section B: Worker Information

Name:
Address:
City: Prov: Postal code:
Phone(s): /

Specific division (if applicable):
Occupation: Post Secondary Student Work Placement
Social Insurance Number
Provincial Health Number:
Date of birth: (MM/DD/YYYY) Gender: ☐ Male ☐ Female
Hire date:

Section C: Injury Information

1. Injury date: (MM/DD/YYYY) Fatality? ☐ Yes ☐ No
2. Reported to employer on: (MM/DD/YYYY) 3. Province of injury: SK
4. Area of body injured:
5. Name of health care provider:
6. How did the injury happen?
7. Has the worker lost time from work, due to the injury, after the day of injury? ☐ Yes ... go to question 8 ☐ No ... go to Section E
8. First day off and time worker left work due to this injury: Date: (MM/DD/YYYY) Time: ☐ a.m. ☐ p.m.
9. Has the worker returned to work? ☐ Yes ☐ No If "yes," what was the date the worker returned? (MM/DD/YYYY)
10. Do you have any reason to believe that this is not a work-related incident? ☐ Yes ☐ No If "yes," provide attachment(s) with explanation.

Section D: Wage and Employment Information

11. How is the worker paid? If regular salary: Hourly $ 0 per hour, hours per week; If monthly $
If non-regular: ☐ Piecework ☐ Contractor ☐ Owner/operator ☐ Casual ☒ Other (explain) Student Work Placement
12. Provide gross earnings for the 12 months preceding first day off due to the work injury: $ 0
If less than 12 months, provide gross earnings and time period: $ 0 from (MM/DD/YYYY) to (MM/DD/YYYY)
13. Time lost during the gross earnings period due to: (a) Unpaid sickness: days; (b) Prior WCB claims days; (c) Lack of work: days;
(d) Other days (Explain):
14. Normal working hours for the worker: From ☐ a.m. ☐ p.m. To ☐ a.m. ☐ p.m. Was there shift work involved? ☐ Yes ☐ No
15. Does the worker have regular days off? ☐ Yes ☐ No If "yes," mark which days off: Sun Mon Tue Wed Thu Fri Sat
If "no," mark the days off for the month of the injury, plus one month before and one month after first day off due to injury.

MONTH OF INJURY PERIOD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MONTH AFTER INJURY PERIOD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MONTH BEFORE INJURY PERIOD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

16. TD1 exemptions: ☐ Single ☐ Spouse, if partial Provincial amount $ Federal amount $
☐ Other: $ Number of children 18 years or under:
17. Should compensation payments be made to: ☐ Worker, OR ☐ Employer?

Section E: Declaration

I declare all the information provided is true and correct. I understand that criminal prosecution or penalties may result from any attempt to (1) obtain compensation benefits by fraudulent means and/or (2) prevent collection of compensation benefits.

(MM/DD/YYYY)			Please print & sign form before mailing/faxing.
Date	Name (please print)	Title	Signature

When writing to the WCB, please print name and claim or firm number.

MISSION: ZERO