Employee Injury Reporting Procedure

Langara College
100 West 49th Avenue, Vancouver, BC V5Y 2Z6

Under the Workers Compensation Act, the College is obligated to report all work-related injuries to WorkSafeBC.

EMPLOYEE/FACULTY MEMBER

☐ 1. **If injured or require medical attention**, call **4444** to obtain First Aid from an Occupational First Aid Attendant (OFAA). If you are injured or require medical attention while performing work at an offsite location, **contact First Aid at the worksite or see a medical doctor**.

☐ 2. The OFAA will administer First Aid and complete a First Aid Report.

☐ 3. **Immediately advise your supervisor of the injury** and have them complete the **WorkSafe Form 7**.

☐ 4. **As an employee, complete the WorkSafe Form 6** and submit the form to WorkSafe per the instructions, or **call WorkSafe at 1-888-967-5377** to report your workplace injury.

SUPERVISOR/MANAGER/DEPARTMENT CHAIR

☐ 1. **If a workplace injury is reported to you, complete the WorkSafeBC Form 7 within 48 hours of the incident**

- Complete the following sections:
  - Worker Information and Incident Information sections (number 1 to 26)
  - If employee/faculty member has missed time from work due to the injury, complete Wage Information section and Return-to-work information (number 27 – 42)
- Send completed Form 7 to the Coordinator, WRAP in Human Resources

☐ 2. **Did the employee/faculty member visit a doctor or hospital to treat the injury and/or miss time from work?**

NO – No further action is required

YES – Please contact the Coordinator, WRAP at 604-323-5173 to initiate an incident investigation.

Information and forms can be found online at:
https://langara.ca/departments/human-resources-payroll/employee-resources/policies-guidelines.html

WORK SAFE BC

APPLICATION FOR COMPENSATION AND REPORT OF INJURY OR OCCUPATIONAL DISEASE

For your convenience, WorkSafeBC offers three options for reporting a work-related injury and filing a claim:

1. **Call our Teleclaim Centre** — The fastest and easiest way to report an injury and file a **TIME-LOSS CLAIM** is to call us at **1.888.WORKERS** (1.888.967.5377). One of our knowledgeable representatives will take your information over the phone, explain the process, and refer you to services to aid with your recovery and return to work. Teleclaim is available Monday to Friday, from 8 a.m. to 6 p.m.
2. **Report your injury online** — Go to **worksafebc.com** and select "Report injury or illness" to input your information. You can submit your report online and, once submitted, you can follow the status of your claim online.
3. **Submit the paper form** – Clearly **PRINT** your information on the form below, sign it, and submit it by fax or mail.
   FAX: 604.233.9777 in Greater Vancouver, or toll-free within BC at **1.888.922.8807**
   MAIL: WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

For assistance, please call:

A. Claims Call Centre at 604.231.8888 or toll-free throughout Canada at 1.888.967.5377, Monday–Friday, 8 a.m. to 6 p.m.

B. The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. 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

Information about you

WorkSafeBC claim number *(if known)*		Customer care number *(if known)*	
Worker last name		First name	Middle initial
Preferred first name		Gender M ❒ F ❒	
Date of birth *(yyyy-mm-dd)* - -	Personal health number *(from BC CareCard)*	Social insurance number	
Address line 1		Address line 2	
City	Province/state	Country *(if not Canada)*	Postal code/zip
Home phone number *(please include area code)*		Business phone number *(please include area code)*	Business extension
Do you need an interpreter? Yes ❒ No ❒	Preferred language	What is your dominant hand? Left ❒ Right ❒	Height / Weight

Information about your employer

Employer organization name			
Type of business *(if known)*		Operating location *(if known)*	
Address line 1		Address line 2	
City	Province/state	Country *(if not Canada)*	Postal code/zip
Employer contact last name	First name	Employer phone number *(please include area code)*	Extension

Information about your employment

1. What is your occupation?	2. Have you been employed by this firm for less than 12 months? Yes ❒ No ❒	3. If yes, start date *(yyyy-mm-dd)*

4. At the time of injury, were you *(please check all that apply)*

Permanent ❒	Apprentice ❒	Self-employed ❒	Casual ❒
Temporary ❒	Volunteer ❒	Principal/partner or relative of employer ❒	Other *(please specify)* ❒
Full time ❒	Student ❒	Fisher ❒	
Part time ❒	New entrant to workforce ❒	Hired on a contract basis ❒	

5. How many employers do you have?

WORK SAFE BC

Application for Compensation and Report of Injury or Occupational Disease *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number

Social insurance number	Personal health number from BC CareCard

Incident information

6. Date and time of incident *(yyyy-mm-dd)*
a.m. ❒ p.m. ❒ **OR**

7. Period of exposure resulting in occupational disease *(yyyy-mm-dd)*
From To

8. Have you reported the injury/exposure to your employer? Yes ❒ No ❒

9. The injury or disease was first reported to employer on *(yyyy-mm-dd)*

(please check one)
TO: First aid ❒ Supervisor ❒ Office ❒
Other ❒ *(please specify)*

10. Name of person reported to

11. If no, provide reason for not reporting to your employer

12. Describe how the incident happened

13. Describe the injury in detail *(what part of the body was injured)*

14. Side of body injured
Left ❒ Right ❒ Both ❒ Not applicable ❒

15. Describe the work incident location *(address, city, province)* and where incident occurred *(e.g. shop floor, lunchroom, parking lot)*

16. Did your injury(ies) or exposure result from a specific incident? Yes ❒ No ❒

17. Contributing factors – select AT LEAST ONE, and as many as applicable

Lifting	❒ _____ lb ❒ kg ❒	Struck	❒	Animal bite	❒
Overexertion	❒	Crush	❒	Assault	❒
Repetitive *(activity repeated over and over again)*	❒	Sharp edge	❒	Motor vehicle accident	❒
Slip or trip	❒	Fire or explosion	❒	Unsure/other *(please explain below)*	❒
Twist	❒	Harmful substance in the work environment	❒		
Fall	❒				

18. Were there any witnesses? Yes ❒ No ❒

19. Did the incident occur in British Columbia? Yes ❒ No ❒

20. Were your actions at time of injury for your employer's business? Yes ❒ No ❒

21. Did the incident occur on employer's premises or an authorized worksite? Yes ❒ No ❒

22. Did the incident occur during your normal shift? Yes ❒ No ❒

23. Were you performing your regular work duties at the time of the incident? Yes ❒ No ❒

24. Did you receive first aid? Yes ❒ No ❒ Date *(yyyy-mm-dd)*

If yes, please provide first aid attendant name *(if known)*

25. Did you go to hospital, clinic, or visit a physician or qualified practitioner? Yes ❒ No ❒ Date *(yyyy-mm-dd)*

If yes, please provide provider name *(if known)*

If yes, please provide provider address *(if known)*

26. Prior to this incident, did you have any recent pain or disability in the area of your injury? Yes ❒ No ❒

WORK SAFE BC

Application for Compensation and Report of Injury or Occupational Disease *(continued)*

Worker last name	First name	Middle initial	WorkSafeBC claim number

Social insurance number	Personal health number from BC CareCard

Wage information

27. Did you miss work beyond the date of injury or exposure? Yes ❒ No ❒

If NO WORK WAS MISSED and NO CHANGE to duties/pay, proceed to bottom of page to sign, date, and submit this report. If WORK WAS MISSED or if duties/pay have been MODIFIED, please answer ALL questions on this form.

28. What is your current **base salary** amount for this employment position at the time of injury $ Hourly ❒ Daily ❒ Weekly ❒ Monthly ❒ Yearly ❒

29. Please provide total gross amount of earnings you receive from other employers $ Hourly ❒ Daily ❒ Weekly ❒ Monthly ❒ Yearly ❒

30. Do you receive other amounts of compensation in addition to **base salary**? Yes ❒ No ❒

Do you receive vacation pay on every cheque? Yes ❒ No ❒

If yes, vacation pay _____%

Please select check boxes for any of the following amounts you receive in addition to **base salary** AND provide the amount:

Tips and gratuities ❒ $ _____ Room and board ❒ $ _____

Shift differential ❒ $ _____ Other ❒ $ _____

Overtime ❒ $ _____

31. If you are disabled from work, will you continue to receive:

Base salary? Yes ❒ No ❒

Other amounts of compensation in addtion to **base salary**? Yes ❒ No ❒

Will you continue to receive vacation pay on every cheque? Yes ❒ No ❒

If yes, vacation pay _____%

Please select check boxes for any of the following amounts you will continue to receive in addition to **base salary** AND provide the amount:

Tips and gratuities ❒ $ _____ Room and board ❒ $ _____

Shift differential ❒ $ _____ Other ❒ $ _____

Overtime ❒ $ _____

32. Provide your **gross** earnings for the past 3 months or 12 weeks prior to the date of injury or exposure $ 3 months ❒ 12 weeks ❒

33. Do you work a fixed-shift rotation? Yes ❒ No ❒

34. If no, please explain

35. If yes, show your normal work week by entering the paid hours

Sun	Mon	Tue	Wed	Thu	Fri	Sat

36. Did you continue to work past day of injury? Yes ❒ No ❒

37. Last day worked *(yyyy-mm-dd)*

38. Number of hours you were scheduled to work on last day worked

39. Number of hours you worked on last day worked

40. Number of hours paid by your employer on last day worked

Return-to-work information

41. Have you returned to work? Yes ❒ No ❒

42. If **YES**: Date you returned to work *(yyyy-mm-dd)*

Since the return to work, has there been any change to your work duties or will there be any change to your hours of work, your work schedule, or your rate of pay? Yes ❒ No ❒

43. If **NO**: Does your employer have any **modified** or **transitional** duties available? Yes ❒ No ❒

Have the modified or transitional duties been offered to you? Yes ❒ No ❒

44. If yes, please describe modified or transitional duties

PLEASE READ CAREFULLY:

I declare all the information I have given on this report is true and correct, and I elect to claim compensation for the above-mentioned injuries or disease. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation benefits without advising WorkSafeBC (the Workers' Compensation Board). I authorize WorkSafeBC and the Workers' Compensation Appeal Tribunal to view or obtain a copy of records pertaining to my examination, treatment, history, and employment from any source whatsoever, including records of physicians, qualified practitioners, medical insurers, hospitals, and any employer. I understand the information is collected, used, and disclosed under the authority of the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. I acknowledge that WorkSafeBC may obtain and disclose information from my claim to my employer for the purpose of appeal, or may disclose such information to others in accordance with the law, including the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

45. Worker signature

46. Date of report *(yyyy-mm-dd)*

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.

WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

RESET

EMPLOYER'S REPORT OF INJURY OR OCCUPATIONAL DISEASE

As an employer, the *Workers Compensation Act* requires you to submit this report **within three days** of an injury to one of your workers, even if you disagree with the claim. By submitting your report promptly, you avoid penalties and delays in the adjudication of the claim. Please report using one of the following options:

1. **Online — The quickest and easiest option**: The online screen application customizes questions to the worker's injury. You can save your report and update it later with new information. Once submitted, you can follow the status of the claim online. Go to **WorkSafeBC.com** and select "Report an injury or illness."
2. **Fillable PDF form**: Type in your details online, print the form, and submit it by **FAX** or **MAIL**. Go to **WorkSafeBC.com** and select "Report an injury or illness."
3. **Paper form**: Clearly PRINT details, sign the form, and submit it by **FAX** or **MAIL**.
   FAX: **604 233-9777** in Greater Vancouver or **toll-free** within BC at **1 888 922-8807**
   MAIL: WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

Employer information

WorkSafeBC claim number *(if known)*				
Employer's name *(as registered with WorkSafeBC)*				Type of business
WorkSafeBC account number		Classification unit number		Operating location number
Employer address line 1 *(mailing)*		Employer contact last name		First name
Employer address line 2 *(mailing)*		Employer contact telephone *(and area code)*	Extension	Employer contact fax *(and area code)*
City	Province/state	Employer payroll contact last name		First name
Country *(if not Canada)*	Postal code/zip	Employer payroll contact telephone *(and area code)*	Extension	Employer payroll contact fax *(and area code)*

Worker information

Worker last name	First name	Middle initial	Gender M ☐ F ☐
Date of birth *(yyyy-mm-dd)* - -	Home phone number *(include area code)*	Social insurance number	
Address line 1		Address line 2	
City	Province/state	Country *(if not Canada)*	Postal code/zip

1. What is the worker's occupation?

2. Has the worker been employed by this firm for less than 12 months? Yes ☐ No ☐

3. If yes, start date *(yyyy-mm-dd)*

4. At the time of injury, was the worker *(check all that apply)*

Permanent	☐	Apprentice	☐	Self-employed	☐	Casual	☐
Temporary	☐	Volunteer	☐	Principal/partner or relative of employer	☐	Other *(please specify)*	☐
Full time	☐	Student	☐	Fisher	☐		
Part time	☐	New entrant to workforce	☐	Hired on a contract basis	☐		

Incident information

5. Date of incident *(yyyy-mm-dd)* - -
   Time of incident *(hh:mm)* a.m. ☐ p.m. ☐ **OR**

6. Period of exposure resulting in occupational disease *(yyyy-mm-dd)*
   From To

7. Did worker report injury or exposure to employer? Yes ☐ No ☐ ▶

8. The injury or disease was first reported to employer on *(yyyy-mm-dd)*
   (please check one)
   To: First aid ☐ Supervisor ☐ Office ☐
   Other ☐ *(please specify)*

9. Name of person reported to

10. Describe how the incident happened

11. Describe the injury in detail *(what part of the body was injured)*

12. Side of body injured
    Left ☐ Right ☐ Both ☐ Not applicable ☐

13. Describe the work incident location *(address, city, province)* and where incident occurred *(e.g. shop floor, lunchroom, parking lot)*

14. Did the injury(ies) or exposure result from a specific incident?
    Yes ☐ No ☐

WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

Employer's Report of Injury or Occupational Disease *(continued)*

If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

Worker last name	First name	Middle initial	WorkSafeBC claim number *(if known)*

Social insurance number	Personal health number *(CareCard)*	Date of incident *(yyyy-mm-dd)*	Date of birth *(yyyy-mm-dd)*
		- -	- -

15. Contributing factors — select AT LEAST ONE, and as many as applicable

Lifting	☐	lb ☐ kg ☐			
Overexertion	☐	Struck	☐	Animal bite	☐
Repetitive *(activity repeated over and over again)*	☐	Crush	☐	Assault	☐
Slip or trip	☐	Sharp edge	☐	Motor vehicle accident	☐
Twist	☐	Fire or explosion	☐	Unsure/other *(please explain below)*	☐
Fall	☐	Harmful substances in the work environment	☐		

16. Were there any witnesses? Yes ☐ No ☐	17. Did the incident occur in British Columbia? Yes ☐ No ☐
18. Were the worker's actions at time of injury for the purpose of your business? Yes ☐ No ☐	19. Did the incident occur on employer's premises or an authorized worksite? Yes ☐ No ☐
20. Did the incident happen during the worker's normal shift? Yes ☐ No ☐	21. Was the worker performing their regular duties at the time of the incident? Yes ☐ No ☐
22. Did the worker receive first aid? Yes ☐ No ☐ Date *(yyyy-mm-dd)* ►	If yes, please provide first aid attendant name *(if known)*
23. Did the worker go to hospital, clinic, or visit a physician or qualified practitioner? Yes ☐ No ☐ Date *(yyyy-mm-dd)* ►	If yes, please provide provider name *(if known)*
If yes, please provide provider address *(if known)*	
24. Are you aware of any recent pain or disability in the area of the worker's reported injury? Yes ☐ No ☐	
25. Do you have any objections to the claim being allowed? Yes ☐ No ☐ ►	If yes, please explain

Wage information

26. Did the worker miss any time from work beyond the date of injury or exposure? Yes ☐ No ☐

If NO WORK WAS MISSED and NO CHANGE to duties/pay, proceed to bottom of page to sign, date, and submit this report.
If WORK WAS MISSED or if duties/pay have been MODIFIED, please answer ALL questions on this form.

27. Provide the **base salary** amount for this employment position at the time of injury
$ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

28. Does worker receive other amounts of compensation in addition to **base salary**? Yes ☐ No ☐
Does worker receive vacation pay on every cheque? Yes ☐ No ☐
If yes, vacation pay _____%

Please select check boxes for any of the following amounts worker receives in addition to **base salary** AND provide the amount for each:
Tips and gratuities ☐ $_____ Room and board ☐ $_____
Shift differential ☐ $_____ Other ☐ $_____
Overtime ☐ $_____

29. If worker is disabled from work, will you continue to pay:
Base salary? Yes ☐ No ☐
Other amounts of compensation in addition to **base salary**? Yes ☐ No ☐
Will worker receive vacation pay on every cheque? Yes ☐ No ☐
If yes, vacation pay _____%

Please select check boxes for any of the following amounts worker will continue to receive in addition to **base salary** AND provide the amount for each:
Tips and gratuities ☐ $_____ Room and board ☐ $_____
Shift differential ☐ $_____ Other ☐ $_____
Overtime ☐ $_____

30. Provide the amount of **gross** earnings for the past 3 months or 12 weeks prior to the date of injury or exposure
$ 3 months ☐ 12 weeks ☐

31. Does the worker have a fixed-shift rotation? Yes ☐ No ☐

32. If no, please explain

33. If yes, show the normal work week by entering the paid hours

Sun	Mon	Tues	Wed	Thu	Fri	Sat

34. Did the worker continue to work past day of injury? Yes ☐ No ☐	35. Last day worked *(yyyy-mm-dd)*	
36. Number of hours scheduled to work on last day worked	37. Number of hours worked on last day	38. Number of hours paid by employer on last day worked

WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

Employer's Report of Injury or Occupational Disease *(continued)*

If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

Worker last name	First name	Middle initial	WorkSafeBC claim number *(if known)*

Social insurance number	Personal health number *(CareCard)*	Date of incident *(yyyy-mm-dd)*	Date of birth *(yyyy-mm-dd)*
		- -	- -

Return-to-work information

39. Has the worker returned to work?
Yes ☐ No ☐

40. If **YES**: Date *(yyyy-mm-dd)*

Since the return to work, have the worker's duties, hours of work, work schedule, and/or rate of pay changed? Yes ☐ No ☐

41. If **NO**: Do you have any modified or transitional duties available?	42. If yes, please describe modified or transitional duties
Yes ☐ No ☐ Have the modified or transitional duties been offered to the worker? ► Yes ☐ No ☐	

Signature and report date

43. Employer signature	44. Employer title	45. Date of report *(yyyy-mm-dd)*

For assistance, please call our Claims Call Centre at 604 231-8888 or toll-free within Canada at 1 888 967-5377.
Please note: If you have concerns with this claim, please contact the officer handling the claim at the WorkSafeBC office to make known your objections or you may submit a letter detailing your specific concerns. **Impartial advice on WorkSafeBC claims** — To ensure you have an opportunity to obtain impartial advice on WorkSafeBC claims matters, the BC legislature has provided impartial advisers. **Employers' Advisers** are available to provide independent advice or clarification on a WorkSafeBC claim related to your firm. For additional information on the Employers' Advisers, please refer to their web site at www.labour.gov.bc.ca/eao/.

Lower Mainland	**Kelowna**	**Prince George**	**Victoria**
604 713-0303 (Richmond)	250 717-2050	250 565-4285	250 952-4821
Toll free 1 800 925-2233	1 866 855-7575	1 888 608-8882	1 800 663-8783

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.