WorkplaceNL

MAIL FORM TO:
146-148 Forest Road
P.O. Box 9000 St. John's NL A1A 3B8
CALL US AT:
t 709.778.1000
t 1.800.563.9000

FAX FORM TO:
f 709.778.1302
1.800.276.5257

VISIT US AT:
workplacenl.ca

6

Worker's Report of Injury

SECTION A - GENERAL INFORMATION

1	Last name	First name	Initial	Date of birth yyyy/mm/dd	Gender ☐ M ☐ F
	Mailing address	Apt.	City/town	Province	Postal code
	Home telephone	Work phone	Social Insurance Number	MCP	
	Cell phone	Email			
2	Occupation	Are you the owner / operator of this business? ☐ Yes ☐ No	Are you employed as part of a government-funded program? ☐ Yes ☐ No		
3	Employer			Phone	
	Mailing address City / Town	Street address if different City / Town			
	Province Postal code	Supervisor's name	Supervisor's phone		

SECTION B - INJURY / INCIDENT INFORMATION

4	Date / time of injury / incident yyyy/mm/dd hh:mm ☐ AM ☐ PM	Did this injury develop over time without a specific injury / incident? ☐ Yes ☐ No	Date / time injury / incident was reported to employer: yyyy/mm/dd hh:mm ☐ AM ☐ PM

5 Did this injury / incident occur outside Newfoundland and Labrador? ☐ Yes ☐ No

6 To whom was the injury / incident first reported?	Last name	First name	Occupation	Phone

7 Indicate part(s) of body affected. e.g. right arm, left leg, low back.

8 How did the injury / incident occur or the condition develop?

9 Did the injury / incident happen on the employer's property or worksite? ☐ Yes ☐ No Specify where:

10 Were there any witnesses to this injury / incident? ☐ Yes If yes, please specify name and contact information, if available. ☐ No

	Last name	First name	Address	Work phone	Home phone
1.					
2.					

11 Was the injury / incident caused by anything listed at right? ☐ Yes ☐ No

If yes, tick applicable:
☐ Motor vehicle accident (e.g. forklift, car, truck, ATV)
☐ Malfunction of product / equipment
☐ Other: _____
☐ Person(s) not employed by your employer
☐ Slip and fall

If *yes* to Question 11, was someone else involved? ☐ Yes If yes, please specify name and contact information, if available. ☐ No

	Last name	First name	Address	Work phone	Home phone
1.					

SECTION C - MEDICAL INFORMATION

12	Did you seek medical attention? ☐ Yes ☐ No	Date of visit yyyy/mm/dd	Were you seen in emergency? ☐ Yes ☐ No If *yes*, which hospital? _____	Did you require hospitalization for more than two days? ☐ Yes ☐ No

13	Name the health care person you saw during this first visit:	Last name	First name	Address if known
14	Name your family physician:	Last name	First name	Address if known

15 Have you experienced similar problems in the past? ☐ Yes If yes, explain in chart below. If related to a previous claim, record the number. ☐ No

Similar problems	Year	Part of body	Location *if applicable*	WorkplaceNL claim number
1.			☐ Right ☐ Centre ☐ Left	
2.			☐ Right ☐ Centre ☐ Left	
3.			☐ Right ☐ Centre ☐ Left	

This information is collected under the authority of the Workplace Health, Safety and Compensation Act, 2022 to determine entitlement to benefits and manage your claim.

Worker's name | Social Insurance Number

SECTION D - RETURN-TO-WORK INFORMATION

16 Did you stop working beyond the day of the injury? ☐ No ☐ Yes →

When did you stop working beyond the day of the injury? yyyy/mm/dd hh:mm ☐ AM ☐ PM

Have you been offered or participated in alternate / modified duties? ☐ Yes ☐ No

Were your work duties and / or hours modified or changed? ☐ Yes ☐ No

Have you since returned to work? ☐ No ☐ Yes → When? yyyy/mm/dd

SECTION E - EARNINGS INFORMATION

Complete only if claim involves lost time / early safe return to work greater than the day of injury.

17 At the time of your injury / incident, were you working in a second job? ☐ Yes ☐ No

If *yes*, have you lost time / wages from the second job as a result of the injury / incident? ☐ Yes ☐ No

18 Are you receiving other benefits in relation to this injury / incident? ☐ Yes ☐ No

If yes, is it: ☐ Short-term or long-term disability insurance benefits ☐ Canada Pension Plan ☐ WorkplaceNL benefits ☐ Other: _____

19 At the time of your injury, were you receiving EI benefits? ☐ Yes ☐ No

20 Indicate the personal income tax credits you are claiming:

- ☐ a. Basic personal amount
- ☐ b. Full equivalent to spouse amount (If not full amount, then d. applies)
- ☐ c. Number of children under age 18 you are claiming _____
- ☐ d. Other (complete a new TD1 and TD1NL available from Canada Revenue Agency at www.cra.gc.ca).

If nothing is indicated above, you will be assumed as (a) basic personal amount.

SECTION F - FISHER'S INFORMATION

To be completed by workers on a fishing vessel.

21 Vessel name | Vessel length (feet) | Are you an owner or part owner of the vessel? ☐ Yes ☐ No

22 Master's name | Master's phone | Master's mailing address City/Town Province Postal code

23 Are your earnings based on a share of the catch? ☐ Yes If yes, describe your share arrangement: _____ ☐ No

	Fish buyer's information If you need more space, please use an additional sheet.				Start of fishing period	End of fishing period
	Name	Phone	Fax	Gross sales	yyyy/mm/dd	yyyy/mm/dd
1.						
2.						
3.						

Attach pay stubs or other verification from the fish buyer, if available.

SECTION G - INFORMATION ACCESS AUTHORIZATION

24 Do you authorize another individual (e.g., union representative, MHA) to act on your behalf and access your information regarding this claim? ☐ Yes ☐ No

This authorization will remain in effect until you notify WorkplaceNL of a change using Form 13.

Last name	First name	Address	Organization if applicable	Phone

SECTION H - SIGNATURE, CONSENT AND DECLARATION (signing this consent enables WorkplaceNL to process your claim.)

25 I believe this is an injury related to my work and I declare that all information I have provided to WorkplaceNL is true and correct. I understand I must immediately inform WorkplaceNL if I return to, or become capable of, performing work of any kind.

I consent to WorkplaceNL collecting and using all information it considers relevant for the purposes of determining my entitlement to benefits and managing my claim under the Workplace Health, Safety and Compensation Act, 2022, (the Act). This includes, but is not limited to, collecting and using information from physicians, hospitals, health care providers, and employers pertaining to my examinations, treatment, medical history, injury/incident and employment.

I consent to WorkplaceNL disclosing to my employer or my Employer's Authorized Representative, a summary of my injury costs, which is disclosed to the employer for the purpose of verifying claims' costs. I consent to WorkplaceNL disclosing to external physicians, hospitals and health care providers all relevant information necessary for the purpose of determining entitlement to benefits and managing my claim under the Act.

I understand information may be collected, used and/or disclosed for other purposes and/or disclosed to other parties only as permitted by law, including, but not limited to, the Act, the Access to Information and Protection of Privacy Act, and the Personal Health Information Act, and I agree that this consent is valid for the duration of my claim.

Name please print _____ Signature _____ Date yyyy/mm/dd

SECTION I - CO-OPERATION AND OBLIGATION

All workers and employers must co-operate in early and safe return to work. A re-employment obligation may exist if there are 20 or more workers with your employer and if you have been continuously employed for more than one year. Contact your employer to determine if this re-employment obligation applies to you.

If attaching additional information, put your first name, last name and Social Insurance Number at the top of each sheet.

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DIRECT DEPOSIT AUTHORIZATION
WORKERS

To ensure benefits are paid in a timely manner, direct deposit information can be provided using one of the following methods:

1. Visit www.myworkplacenl.ca. Select Submit Documents and Requests.
2. Complete sections A and C and attach a void cheque or pre-authorized payment form (available from your financial institution).
3. Complete form below including account information and stamp from your financial institution.

Section A: Worker information

Worker's last name	Worker's first name	Initial	Claim number (if known)

Mailing address	City / Town		

Primary phone	Work phone	Province	Postal code

Section B: Account information (not required if void cheque or pre-authorized payment form attached)

Transit No. | Institution No.

Account No.

Name(s) of account holder(s)

Financial Institution Stamp Here

Section C: Signature

I, as the worker/dependent, am entitled to receive payment(s) from WorkplaceNL and authorize WorkplaceNL to deposit the payment(s) directly into my account until further notice.

X

Signature of worker/dependent

Year | Month | Day

This information is collected under the authority of the Workplace Health, Safety and Compensation Act, 2022 to process benefits/payments and manage your claim. For more information, please see WorkplaceNL's Policy GP-01: Information Protection, Access and Disclosure available on workplacenl.ca or by calling 1.800.563.9000.

Use this form when:

- You have a work-related injury / incident or recurring work-related injury or illness that results in any of the following:
  - medical attention;
  - loss of earnings; and / or
  - lost-time from work.

  This includes injuries or illnesses that occurred over time as well as those caused by an event.
- If you feel your current symptoms are related to a previous work injury, complete this form based on your current situation, as opposed to restating what happened at the time of your initial injury. For example, for question 4 under section B "Date/time of injury/incident," enter the date and time your current symptoms developed or the date a new incident happened which caused your current symptoms.
- If you are a partner, proprietor or independent operator (also referred to as owner/operator on this form) and you have experienced a work-related injury, coverage will be extended only when optional personal coverage has been purchased from WorkplaceNL.

Points to remember:

- Complete and accurate information is important to avoid delays in processing your claim.
- If you have additional information, attach additional pages and include your name and SIN on each page.
- Sign page 2 so we can process your claim.

Section A General Information

Occupation & Employer Information

- This refers to your occupation and employer at the time of your injury / incident.

Section B Injury / Incident Information

How did your injury / incident occur or the condition develop?

- Explain how the injury / incident happened and what you were doing at that time. This may include information such as: sizes, weights and names of objects involved; description of any machinery, tools or vehicles used at the time of the injury / incident; environmental conditions (work area, temperature, noise, chemicals, gas, fumes); if another person was involved; or any other information you think is important.

  For example: *"I was moving boxes in the storage room. I lifted a 40-pound box from the floor to put on a shelf. I twisted to the right while lifting, and hurt my upper back."*
- If your condition developed over time, a detailed description of the work you do is helpful. Explain how often you do a particular task; the sizes and weights of objects involved; how long you have been doing this work; and if there have been any recent changes to your schedule and / or tools or products you use.

  For example: *"I am a cashier and continuously scan products for my eight-hour shift using my left arm. The products can weigh from a few ounces up to 10 pounds. The belt hasn't been working properly for the past three weeks and I reach further than I usually do to ring things in. Recently I started to have pain in my left elbow."*

Did the injury / incident happen on the employer's property or worksite?

- Detailed information as to where the injury / incident happened is important to process your claim. For example, if on the employer's premises, where did it occur? The shipping area, paint shop, or warehouse? If not on the employer's premises, where did it happen?

  For example: *"I work for a cleaning company and was working at a retail store when the injury happened. The store was ABC Clothing on Anywhere Street."*

Section D: Return-to-work Information

- You and your employer may be able to change your duties and / or hours so you can stay at work while you are receiving medical treatment for your injury. This is called early and safe return-to-work.
- An early and safe return-to-work plan should be developed in co-operation with your employer, based on the functional abilities information from your health care provider(s).

Section E: Earnings Information

- If you are off work for more than one day, or have an early and safe return-to-work plan of more than one day, you may be entitled to wage-loss benefits. You should complete this section so WorkplaceNL can make this determination.

Section H: Signature, Consent and Declaration

- Signing the Form 6 Consent enables WorkplaceNL to process your claim.
- For more information on your rights and our personal information practices please see our Personal Information Privacy Statement, available on line or by contacting WorkplaceNL.

Additional information on WorkplaceNL's access, release and protection of your information can be found in Policy GP-01: "Information Protection, Access and Disclosure," available at **www.workplacenl.ca** or by calling WorkplaceNL's Information Officers at **1.800.563.9000**.

Additional Worker Information

Worker's role in early and safe return to work

The main focus of early and safe return to work is to enable you to remain at the workplace following an injury or to return to the workplace in a safe and timely manner if you have already lost time from work.

Going back to work may involve making changes to the duties and/or the hours of work. It may also involve changes to the workplaces such as acquiring equipment or other devices to help you with your return to work.

Staying in touch with work

It is important to stay connected to your workplace following an injury. If your injury prevents you from performing your regular job duties, both you and your employer are required to work together to identify suitable and available employment, even while you are receiving medical treatment for your injury.

During each medical appointment, your doctor will provide you with a copy of their report (form MD) for your records and a second copy to bring to your employer. The employer's copy of the doctor's report does not contain your personal medical information; it simply identifies your functional abilities as a result of the injury.

It is extremely important for you to provide this report to your employer by the next working day after each doctor's visit. This will enable you to assist your employer in identifying suitable job duties so you can continue working without aggravating your injury. If you work in a unionized environment, you may want to involve your union representative in this process.

Finding the right duties

When identifying early and safe return-to-work opportunities with your employer, the first priority should be to maintain the connection to your pre-injury job at some level. Where this is not possible, it is important to work with your employer to identify suitable and available employment that is within your physical capabilities. If you and your employer require any assistance during this process, you should contact your case manager.

Documenting a plan

Once you and your employer have identified suitable job duties that are in keeping with your abilities, you will complete an early and safe return-to-work plan that outlines the agreed upon schedule and progression of duties. If any change occurs to this plan, you must immediately notify your case manager. Your early and safe return-to-work plan should also outline the scheduled hours and the hourly wage earned. This information will then be used to determine if there is any entitlement to compensation during your return-to-work process.

Communicating progress

Communication is critical during early and safe return to work. The frequency and method of communication between you and your employer will be determined by the employer's procedures. However, we recommend you contact your employer weekly during the early and safe return-to work-program. You should contact them immediately if there is an improvement or deterioration in your physical condition that could affect your return-to-work plan. It is also important to keep your case manager updated on your progress.

Worker's role in occupational health and safety (OHS)

Worker's duties:

- Protect your health and safety and that of co-workers and others at or near the workplace;
- Co-operate with your employer, co-workers, OHS committee/worker health and safety representative/workplace health and safety designate, and anyone exercising a duty imposed under OHS legislation;
- Follow instructions and training;
- Report hazardous conditions; and
- Properly use all safety equipment, devices and clothing.

Workers' rights:

- Know about workplace hazards;
- Participate and assist in identifying and resolving OHS issues; and
- Refuse unsafe work.