WCB Accident Report

Occupation: _____ WCB Claim No.: _____

Employer Address / Phone: _____

Date of Accident: _____ Time: _____ A.M. ☐ P.M. ☐

Who rendered the first treatment?	
First Aid ☐ Walk-in Clinic ☐ Hospital ☐	Other ☐:
Have you had similar injuries in the past?	**If yes – explain**
Yes ☐ No ☐	
Have you been disabled from work?	**If yes – explain**
Yes ☐ No ☐	

Please briefly describe the accident:

1) Where did the accident occur?
2) How did it happen?
3) Describe your injury – (Pain/Loss of Function)