

Employer 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	Gender	Job Title			

Injury 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 separate sheet if necessary.)	
City and province where incident occurred	
If the incident occurred out of province, is the worker's usual place of employment in Manitoba? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Had the worker been employed outside of Manitoba for 6 months or longer at the time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the incident occur on your premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, specify name and address of premises where incident happened.

Name and Address of Doctor(s) and/or Hospital(s) that 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?		<input type="checkbox"/> AM <input type="checkbox"/> PM
Has the worker returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	<input type="checkbox"/> AM <input type="checkbox"/> PM
Are you continuing to pay the worker during time loss? <input type="checkbox"/> Yes <input type="checkbox"/> 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 is the worker's current hourly wage?	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

For faster claim reporting, please call 204-954-4321 | Toll free 1-855-954-4321
Fax this form - in Winnipeg: 204-954-4999 | toll free: 1-877-872-3804

Worker's Name	Claim Number	2
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Coverage

Was anyone not employed by you involved in the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give name and address.	
Is the worker a partner, director or sole proprietor of the company? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, at the time of the incident, did the worker reside with the employer or director? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the worker a sub-contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify: <input type="checkbox"/> Construction <input type="checkbox"/> Logging	(Complete appropriate sections below.)
Is the worker an owner operator? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify: <input type="checkbox"/> Courier <input type="checkbox"/> Trucking <input type="checkbox"/> Towing	(Complete appropriate sections below.)

Farming

Is the worker related to the farm owner? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, is the worker registered with WCB? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the worker work in a partnership? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the worker employ other workers? <input type="checkbox"/> Yes <input type="checkbox"/> No

Sub-Contractor in Construction

Does the worker supply any materials or equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify.
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Sub-Contractor in Logging

Does the worker supply any materials or equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify.
Was the worker cutting on the firm's timber sale, timber permit or sawmill license? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the worker a long distance driver? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the worker provide a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many vehicles?

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