WORKERS' COMPENSATION BOARD - Patient Information

1. Have you reported the accident to your employer? Yes ____ No ____

2. Have you consulted a medical doctor or health professional? Yes ____ No ____

If yes, doctor's name: _____

3. Do you have a previous claim? Yes ____ No ____

4. Are you presently on a Workers' Compensation Board pension? Yes ____ No ____

Date of Accident: _____
Month Day Year

WCB Claim #: _____ Social Insurance #: _____

Employer 's Name: _____

Address: _____
Street Apt. #

_____
City Province/Postal Code

Contact Person: _____ Phone #: _____

Description of accident: _____
(please print)

_____

_____

_____

_____

_____

If at any time this claim is denied by the Worker's Compensation Board, it is the responsibility of the patient to cover the costs.

_____ _____
SIGNATURE DATE

_____
Signature of Guardian (if under 18 years old)