WORKSAFE TRAVAIL SÉCURITAIRE NB

Need help? Go to *worksafenb.ca/form-8-10*

Medical Form 8-10

PAGE 1: WORKSAFENB COPY

Provide this page to **WorkSafeNB**. Email securely through WorkSafeNB's MyServices or fax to **1 888 629-4722**. If the page has been emailed or faxed, DO NOT mail the original.

☐ **First Medical Report of Accident or Occupational Disease** ☐ **Medical Progress Report** RESET FORM

PATIENT

Medicare #: Claim #: Visit date: YYYY MM DD Time: 00:00 AM/PM

Last name: First name: ☐ Male ☐ Female ☐ X DOB: YYYY MM DD

Address: City/Town: Province:

Postal code: Phone: Date of incident: YYYY MM DD

Employer: Occupation:

PROVIDER

☐ Acute strain/sprain ☐ Fracture
☐ Repetitive strain injury
☐ Other injury/illness (example: laceration or psych. injury) (please specify):

Body part	Left	Right	Body part	Left	Right
Shoulder	☐	☐	Hand/Digit	☐	☐
Elbow	☐	☐	Hip/Thigh	☐	☐
Wrist	☐	☐	Knee	☐	☐
Forearm	☐	☐	Ankle/Foot	☐	☐

☐ Neck ☐ Upper back ☐ Lower back

Other anatomical structure (not captured above) (please specify):

Concussion/mTBI, head injury with:
☐ Altered mental state ☐ Focal deficit
☐ Amnesia ☐ LOC

Other or previous injury contributing to delayed recovery:

Description of occupational injury/illness (please provide objective/subjective findings):

If medical progress report:
Subjective progress: ☐ Improved ☐ Unchanged ☐ Regressed
Objective progress: ☐ Improved ☐ Unchanged ☐ Regressed
In addition to this form, please attach applicable clinic note(s)/chart(s).

Diagnosis (best working):

Diagnostics ordered: ☐ CT ☐ EMG ☐ MRI ☐ X-ray
Other: Facility:

Treatment plan includes: ☐ Chiro ☐ Physio Specialist referral Dr. Rx:

EMPLOYER NOTE

Physician functional abilities recommendations **(please provide Page 2 of this form to patient)**:

☐ 1. Medically able to perform usual work duties.
☐ 2. Medically able/unable to perform duties as detailed below. WorkSafeNB may arrange a formal assessment of functional abilities.

Function	Able	Unable	Function	Able	Unable	Function	Able	Unable
Bend/Twist	☐	☐	Push/Pull	☐	☐	Upper extremities use	☐	☐
Climb	☐	☐	Sit	☐	☐	Motor vehicle use	☐	☐
Kneel	☐	☐	Stand	☐	☐	Public transportation use	☐	☐
Lift	☐	☐	Walk	☐	☐	Heavy equipment operation	☐	☐

Valid for _____ days (maximum 2 weeks without additional review)

Other limitations (reduced hours, limitations due to medication, etc.):

PROVIDER ACCOUNT

Health care provider type:
☐ Emergency physician
☐ Family physician
☐ Nurse practitioner
☐ Speciality physician
☐ Walk-in clinic

WorkSafeNB payee #:

Provider office service code(s):

Provider address:

City/Town:

Province:

Postal code:

Phone:

Subsection 41(10) of the *Workers' Compensation Act* authorizes you to release this information.

I confirm that by completing this form, I believe the injury or illness to be consistent with the workplace accident or exposure, and in submitting this document, I attest to the accuracy of the information and the adherence to best practice standards. I understand that payment is dependent on legible completion of form.

Print name Signature Date YYYY MM DD

WORKSAFE TRAVAIL SÉCURITAIRE NB

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Medical Form 8-10

PAGE 2: PATIENT/EMPLOYER COPY

Give this page to the **patient** to provide to their employer.

☐ First Medical Report of Accident or Occupational Disease ☐ Medical Progress Report

PATIENT

Claim #: Visit date: YYYY MM DD Time: 00:00 AM/PM

Last name: First name: ☐ Male ☐ Female ☐ X DOB: YYYY MM DD

Address: City/Town: Province:

Postal code: Phone: Date of incident: YYYY MM DD

Employer: Occupation:

Hurt at work? Now what?

It can be overwhelming to know what to do when you've been hurt at work. In such times, it's good to know you have a team of support. This *Medical Form 8-10* (page 2) gets your recovery off to a good start. Please provide this to your supervisor or manager as soon as possible so they are aware of your work capabilities at this time. See the steps for reporting a workplace injury, as well as your option for applying for workers' compensation benefits.

Learn more about workers' compensation and the application process at **worksafenb.ca**.

You are here!

Haven't told your employer about your injury or illness yet? Do it as soon as you can!

Tell your employer.

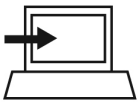
Let your employer know that you've been hurt at work as soon as possible. They can help you get the help you need. They must also help protect others from getting hurt in the workplace.

Get medical attention, if needed.

Give your health care provider as much detail as possible to help them help you. Let them know you were hurt at the workplace.

Give the *Medical Form 8-10* (page 2) to your employer.

This page provides valuable information about your work capabilities to help you and your employer develop next steps.



If you wish to apply for workers' compensation benefits, file an *Application for Workers' Compensation Benefits*.

Benefits can include medical treatment, wage replacement or both. Open the form at worksafenb.ca.

Medical information has been removed from this section in compliance with the *Personal Health Information Privacy and Access Act*.

EMPLOYER NOTE

Physician functional abilities recommendations:

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PROVIDER ACCOUNT

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Print name _____ Signature _____ Date YYYY MM DD