Form 8C
GUIDELINES FOR THE COMPLETION OF FORM 8C, CHIROPRACTOR'S FIRST REPORT OF ACCIDENT

If the patient states that an injury or illness is work related, then ask the question:
Have you or do you intend to report this to the Compensation Commission?
If the answer is **"No"**, then do not complete the form or send any bills to the Commission.
If the answer is **"Yes"**, then get the patient to complete and sign the "Worker Section".

DEFINITIONS FOR RESTRICTIONS AND LIMITATIONS

1. Work Restriction: A work restriction is something a **patient can do, but should not do.**
2. Work Limitation: What a patient is **not physically able to do.**

1. RETURN TO WORK / LIMITATIONS

Employers have a duty to accommodate injured workers. Employees have a duty to accept any reasonable offer of accommodation. If your patient cannot return to full pre-accident duties, please check the appropriate restriction(s) / limitation(s), provide any specifics in the comments section, provide an estimate of the duration of the restriction(s) / limitations(s), and give the bottom copy of the form to your patient to take back to their employer. If you are unsure of your patient's job demands or how the condition may affect on your patient's job, the Commission encourages you to speak with your patient's employer or WorkSafeNB case manager. A work-related functional evaluation or job task analysis may help you match your patient's functional capabilities with job demands.

2. FORM COMPLETION

The worker should complete his/her section **(outlined in blue)** before seeing the chiropractor. The chiropractor completes the remainder **(outlined in orange)** of the form. If the chiropractor is using a medical record report form (e.g. electronic record system) for the visit, this can be used to answer most of the CHIROPRACTOR'S SECTION. Check "Clinical Notes Attached". Complete items 1, 6 and 10 in the CHIROPRACTOR'S SECTION and anything else not covered by the clinical notes.

The "Employer Note" section has an attachment that you should give to the worker to take back to the employer.

The form should be faxed to the Commission at **1 888 629-4722.** Keep the original in your chart.

Completion of the form as instructed in the "Form Completion" section above is required to process the claim and your account.

Additional information may be obtained from the following offices:

WorkSafeNB

Saint John office
1 Portland Street
PO Box 160
Saint John, NB E2L 3X9
Telephone: 506 632-2200
Toll-Free: 1 800 222-9775

Regional Offices:

Bathurst office	**Telephone: 506 547-7300**
Grand Falls office	**Telephone: 506 475-2550**
Dieppe office	**Telephone: 506 867-0525**
Saint John office	**Telephone: 506 632-2200**

Toll-Free Number for all regions: 1 800 222-9775

Toll-Free Physician Enquiry Line 1 877 647-0777

Version date: February 2010

WORKSAFE TRAVAIL SÉCURITAIRE NB

Form 8C

Chiropractor's First Report of Accident

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

Please FAX this form TOLL-FREE IMMEDIATELY to: **1 888 629-4722**
If the form has been faxed, it is not necessary to mail the original.

WORKER'S SECTION:

Medicare No. _____ or Social Insurance No. _____ WorkSafeNB Claim No. _____

Last Name of Worker _____ Given Name(s) _____ ☐ Male ☐ Female

Address _____ City _____ Province _____ Postal Code _____

Worker's Telephone No. _____ Y M D Y M D

Name of Employer _____ Birth Date _____|_____|_____ Date of Accident_____|_____|_____

Have you reported this accident to your employer? ☐ Yes ☐ No If yes, to whom reported?_____

I have reported/intend to report this accident/disease to WorkSafeNB (on *Form 67*) ☐ Reported ☐ Intend to report ☐ Do not intend to report

Upon receipt of this report the WorkSafeNB will contact your employer to request a *Form 67* if one is not already received. By signing this form, you are declaring that you have a work-related accident.

Worker's Signature_____

CHIROPRACTOR'S SECTION:

☐ **Clinical Notes Attached**

1. Date of consultation Y M D _____|_____|_____ Time of consultation: _____

2. Patient's description of work-related accident/disease_____

_____

3. Patient's current symptoms _____

_____

4. Objective findings _____

_____

5. X-rays, etc. ☐ No ☐ Yes _____

_____

6. Clinical impression (**include injury area, specify left/right**) _____ ☐ Left ☐ Right

7. Type of treatment / technique_____

Frequency of treatments (per week) _____ Length of active treatment plan (weeks) _____

8. Is referral to another health care professional required? ☐ No ☐ Yes (specify) _____

9. Is referral for further test(s)/investigation required? ☐ No ☐ Yes (specify) _____

10. Reasons/concerns for referral _____

EMPLOYER NOTE

It is the responsibility of the worker to return this note to their employer.

_____was seen by me on _____.

He/She can return to full duties. ☐ Yes ☐ No, but…

He/She can safely perform normal duties **EXCEPT FOR:**

☐ Some upper extremity limitation/restriction	☐ Lifting
☐ Some lower extremity limitation/restriction	☐ Kneeling
☐ Bending, twisting	☐ Prolonged standing
☐ Prolonged walking	☐ Prolonged sitting

Please expand on limitations/restrictions: _____

_____

CHIROPRACTOR'S ACCOUNT

Name (or stamp)_____

Address _____

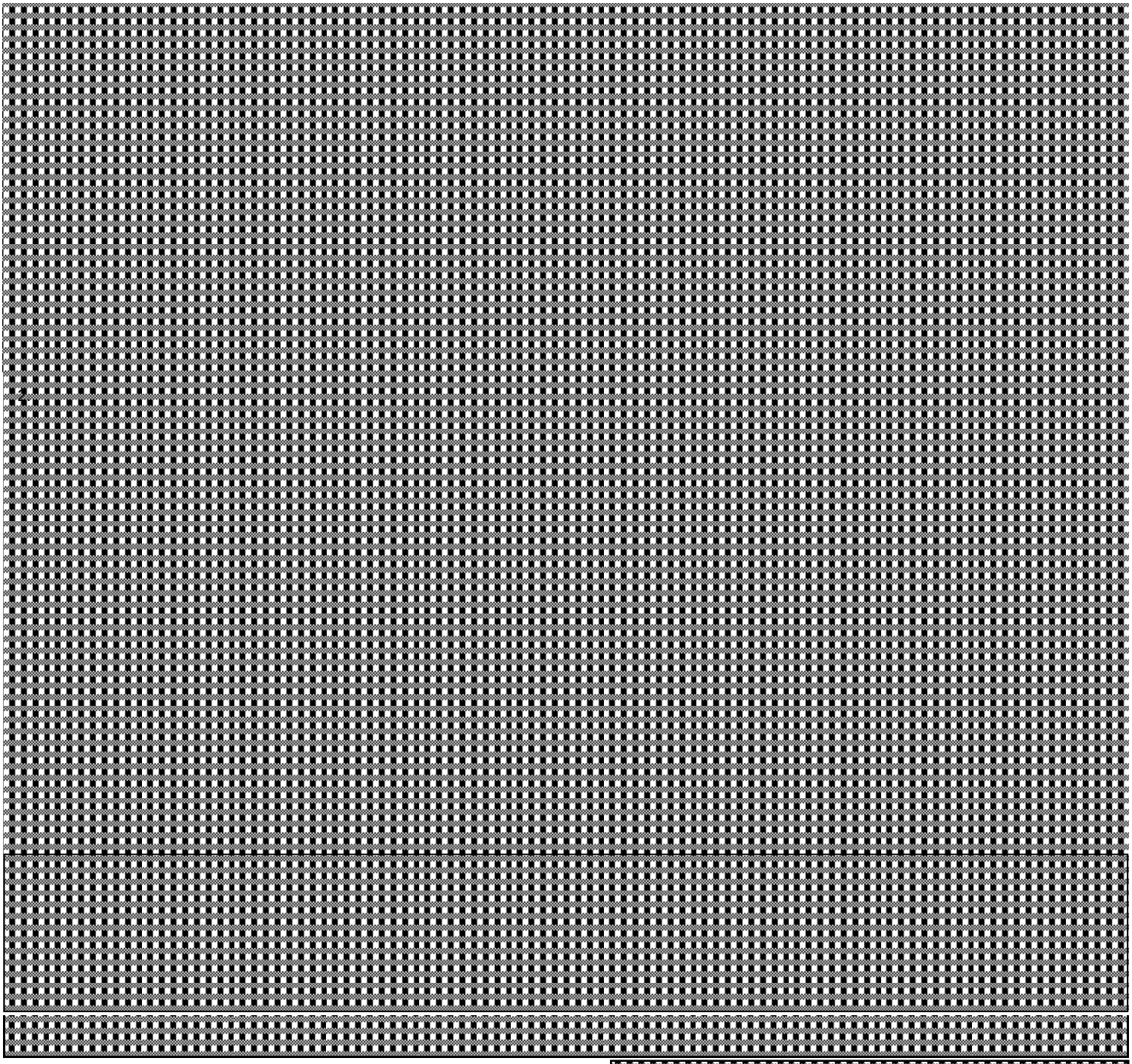
Postal Code _____ WorkSafeNB Payee# _____

Date de Service	Description of Service	Fee
1.		
2.		
3.		
4.		
5.		
	Total	

Chiropractor Name: _____ Signature _____ Date _____ Tel: _____

Comments _____

IMPORTANT: You must give the last page to the worker to return to their employer.



EMPLOYER NOTE
It is the responsibility of the worker to return this note to their employer.

_____ was seen by me on _____.

He/She can return to full duties. ☐ Yes ☐ No, but…

He/She can safely perform normal duties **EXCEPT FOR:**

☐ Some upper extremity limitation/restriction	☐ Lifting
☐ Some lower extremity limitation/restriction	☐ Kneeling
☐ Bending, twisting	☐ Prolonged standing
☐ Prolonged walking	☐ Prolonged sitting

Please expand on limitations/restrictions: _____

_____

Chiropractor Name _____ Signature _____ Date _____ Tel: _____

Comments:

IMPORTANT: It is the responsibility of the worker to return this form to their employer.