

Complete this form if an employee experiences a work-related injury or illness. You must submit this to WorkSafeNB **within three days** of the: date of the accident if the injury or illness may entitle the worker and/or their dependent(s) to wage replacement or medical treatment under New Brunswick's *Workers' Compensation Act*; date the employee is diagnosed with an occupational disease; or date you are notified of the accident/injury or illness by the employee.

Information you must have ready includes:

- Date employee notified you of the accident/injury or illness
- Details on the accident/injury or illness, including date it happened and location
- Start date of any modified work (reduced hours, change in job tasks, etc.), if applicable
- Details of employee's earnings, if the injury or illness resulted in lost time
- Details of employee's hours of work, if the injury or illness resulted in lost time

Additional requirements under *Occupational Health and Safety (OHS) Act*

If an accident results in one of the following injuries, you must report it to WorkSafeNB immediately: loss of consciousness, amputation, fracture other than to fingers or toes, burn that requires medical attention, loss of vision in one or both eyes, deep laceration, admission to hospital as an inpatient, and death. Report these injuries **immediately by phone: 1 800 999-9775**. Learn more about your *OHS Act* obligations on the [WorkSafeNB's Guide to OHS Legislation](#) website/app.

Recovery from a workplace injury or illness requires a team effort. You, your employee, WorkSafeNB and health care providers each have a role to play in a successful recovery.

Keeping your employee connected

Work is good. It provides social connection and a sense of purpose, leading to positive physical and mental health and wellness. Evidence shows it also leads to a speedier recovery. To support employees in their recovery, employers, health care providers and others must make every effort to keep workers connected to the workplace.

- **Employers** must keep in touch with workers throughout the recovery process and maintain connection to the workplace; offer meaningful and productive modified duties or other suitable work that is safe and within the workers' capabilities; ensure supervisors and co-workers support workers during recovery; and collaborate with all return-to-work partners. This applies to all employers in the province, regardless of size, industry or injury risk profile.
- **Employees** must keep in touch with their employer and WorkSafeNB throughout the recovery process; work collaboratively with the employer as they strive to find suitable work that is safe and within their capabilities; and work collaboratively with WorkSafeNB, including providing information as requested.
- **Medical practitioners** provide timely medical care, submit reports to WorkSafeNB, help set expectations for workers, and facilitate return-to-work efforts through effective communication and collaboration with all parties in the return-to-work process.
- **WorkSafeNB** administers health care and wage loss benefits, co-ordinates and monitors required health care and rehabilitation services, helps develop, manage and monitor return-to-work plans, and helps set expectations for workers and employers.

To learn more about the claims process and healthy and safe return to work, please go to worksafenb.ca/employers/. If you have any questions, please contact us toll-free at **1 800 999-9775** (Monday to Friday, 8 a.m. to 4:30 p.m.).

Save this form to your computer or network drive BEFORE you start. Not doing so could result in loss of information. If opening the form in a web browser, we recommend using Internet Explorer or Edge.



Employer Report of Injury or Illness

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Date of report (yyyy-mm-dd)

1. Reporting

Are you reporting this within three days of being notified of the injury or illness? Yes No

Date you were notified

Time reported to you

AM PM

Person who received notification at workplace

Has your employee been made aware of their right to file an application for benefits? Yes No

Does your employee intend to file an application for benefits? Yes No Unknown

Has your employee missed any time from work beyond the date of accident due to this injury/illness? Yes No

2. Employer information

Employer name	Employer number	Operation number
Street address or PO Box		
Town/City	Postal code	Fax number (include area code)
Employer contact name	Position	
Contact's email address	Contact's phone number (business)	Contact's phone number (cell/other)

3. Employee information

Employee's first name	Employee's last name	
Employee's street address	Apt. no.	
Town/City	Postal code	Date of birth (yyyy-mm-dd)
Phone number (home)	Phone number (cell)	Phone number (work/other)
Occupation	Social insurance number	



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4. Injury or illness

How did the injury/illness happen?		
<input type="checkbox"/> It was caused by a specific incident (Date: _____ / Time: <input type="checkbox"/> AM <input type="checkbox"/> PM)		
<input type="checkbox"/> It occurred over a period of time (date first symptoms were noticed: _____)		
<input type="checkbox"/> It's a recurrence of previous workplace-related illness or injury (previous claim number: _____)		
Body part(s) injured	Specify left, right or both if applicable <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	Workplace address/location where injury/accident occurred
Describe the accident in as much detail as possible, including what may have contributed to the injury or illness, OR attach your incident report.		
Did the employee receive medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, name of health care provider/hospital/clinic: Date of visit:	

5. Work function

Offering modified work as soon as possible supports worker recovery and is a legislative requirement for New Brunswick employers.

Did you offer modified work (change of duties/tasks, reduced hours, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when:	Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Full duties <input type="checkbox"/> Modified duties
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6. Hours of work and wage information

Complete this section **only if the employee has lost time** because of the injury or illness.

Your employee is required to provide pay stubs or other acceptable proof of income for the **four weeks immediately before stopping work**.

Last date worked	Did the employee get paid for the full day? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the employee temporarily returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide date(s):
Hire date	Work frequency <input type="checkbox"/> Permanent full-time <input type="checkbox"/> Permanent part-time <input type="checkbox"/> Seasonal <input type="checkbox"/> Casual If seasonal or casual, start date: _____, expected end date: _____	



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<p>Work type</p> <p><input type="checkbox"/> Owner-operator</p> <p><input type="checkbox"/> Subcontractor</p> <p><input type="checkbox"/> Piece work (paid by amount produced/ services completed)</p> <p><input type="checkbox"/> Doesn't apply</p>	<p>Does the employee work the same days every week? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, indicate hours worked each day of the week:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 5px;"> <thead> <tr> <th style="width: 14.28%;">M</th> <th style="width: 14.28%;">Tu</th> <th style="width: 14.28%;">W</th> <th style="width: 14.28%;">Th</th> <th style="width: 14.28%;">F</th> <th style="width: 14.28%;">Sa</th> <th style="width: 14.28%;">Su</th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>If no, average number of hours per day:</p> <p>If no, average number of days per week:</p>	M	Tu	W	Th	F	Sa	Su							
M	Tu	W	Th	F	Sa	Su									
<p>If employed less than 12 months, gross earnings for period before stopping work: _____ (from _____ to _____)</p>															
<p>Gross weekly earnings (including overtime). If varies, provide average of last four weeks: _____</p>															
<p>Gross earnings for the 12 months immediately before stopping work: _____</p>	<p>Hourly rate: _____</p>														
<p>Does the employee have a TD1 Married Exemption reported with payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>															
<p>Have you provided the employee any wage replacement (sick, vacation, etc.) beyond the date of injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>															
<p>If yes, please provide details:</p>															

7. Declaration and consent

<p>Do you have any objections to your employee receiving workers' compensation benefits for this injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>If yes, please explain. (If you need more space, please provide as a separate document.)</p>	



Employer Report of Injury or Illness

- I declare that that all the information provided by me is true and correct to the best of my knowledge.
- I agree to notify WorkSafeNB immediately of any work-related income the employee receives, to my knowledge, while the employee is on workers' compensation benefits, regardless of the source, and of a return to work or any other change in circumstances that may affect the worker's claim application.
- I consent and authorize WorkSafeNB to gather, use, release or disclose information from this report, including medical and financial information, as authorized by law and in accordance with the *Personal Information Protection and Electronic Documents Act*, the *Right to Information and Protection of Privacy Act* and the *Personal Health Information Privacy and Access Act*. WorkSafeNB takes the protection of privacy seriously. Read our [Access to Privacy and Information](#) statement.

Name	Signature	Date
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8. Submission

To submit your report by email, attach the completed document and state "Report of Injury / Illness" in the subject line, then send email to application-demande@ws-ts.nb.ca.

WorkSafeNB reminds you that submitting documents through unsecure email networks increases privacy concerns. For more information, please read WorkSafeNB's [Access to Privacy and Information](#) statement.

Or, you may mail or fax the *Employer Report of Injury or Illness* to:

WorkSafeNB, 1 Portland Street
PO Box 160, Saint John, NB
E2L 3X9
Fax toll-free: 1 888 629-4722