Document Code: S7E

RESET FORM

Employer Report of Injury or Illness

IMPORTANT: 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.

If you are reporting an injury or illness related to hearing loss, please complete the Employer Report of Occupational Hearing Loss rather than this form.

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

1. Employee information

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

2. Employer information

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

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3. Injury or illness

How did the injury/illness happen?

☐ It was caused by a specific incident (Date (yyyy-mm-dd): / Time: ☐ AM ☐ PM)

☐ It occurred over a period of time (date first symptoms were noticed (yyyy-mm-dd):)

☐ It's a recurrence of previous workplace-related illness or injury (previous claim number:)

A recurrence is the return of an injury or illness in which the worker previously received WorkSafeNB benefits (treatment and/or wage replacement). It is not a new accident or injury – but a flare up or recurrence.

Date you were notified (yyyy-mm-dd)	Time reported to you ☐ AM ☐ PM	Person who received notification at workplace

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

Body part(s) injured	Specify left, right or both (if applicable) ☐ Left ☐ Right ☐ Both

Did the injury/illness happen on the employer's premises? ☐ Yes ☐ No

If no, where did the injury/illness happen? (ex: hotel restaurant, store parking lot)?

Did the injury/illness happen in New Brunswick? ☐ Yes ☐ No If no, in which province (or state)?

Describe the type of injury/illness (select all that apply):

☐ Fatality	☐ Fainted	☐ Laceration / Cut / Abrasion
☐ TPI (ex: PTSD, stress, anxiety)	☐ Hearing loss, sudden*	☐ Burn
☐ Cancer	☐ Hernia	☐ Puncture wound
☐ Occupational disease	☐ Amputation (arm/leg)	☐ Bite
☐ Heart / Stroke	☐ Amputation (finger/toe)	☐ Eye injury
☐ Repetitive work injury	☐ Fracture (broken bone)	☐ Dental (teeth)
☐ COVID-19	☐ STI (strain, sprain, bruise)	☐ Needlestick
☐ Infectious disease	☐ Head injury	☐ Other (please explain):
☐ Allergic reaction	☐ Dislocation	
☐ Respiratory / Breathing		

Did your employee seek medical attention from a health care professional (doctor, nurse, physiotherapist, etc.)? ☐ Yes ☐ No ☐ Unknown

Name of healthcare professional (doctor, nurse, physiotherapist, etc.):

Name of facility (hospital, clinic, etc.):

Date seen: Was your employee admitted into hospital overnight? ☐ Yes ☐ No ☐ Unknown

Describe the accident in as much detail as possible, including what may have contributed to the injury or illness, OR attach your incident report. (If a recurrence, describe the circumstances of the flare up.)

*For noise-induced hearing loss, please complete the Employer Report of Occupational Hearing Loss.

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Did the incident involve a motor vehicle accident?	☐ Yes	☐ No
Did the incident involve a slip and fall in a parking lot?	☐ Yes	☐ No
Did the incident occur on a client/customer's property?	☐ Yes	☐ No
Did the incident involve an animal (ex. bite)?	☐ Yes	☐ No

4. 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.)?

☐ Yes ☐ No ☐ Not applicable

If yes, when (yyyy-mm-dd):

Has the employee returned to work? ☐ Yes ☐ No

If yes, when (yyyy-mm-dd):

☐ Full time ☐ Part time / ☐ Full duties ☐ Modified duties

5. 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?
☐ Yes ☐ No
If no, how many hours were paid?

Has the employee temporarily returned to work?
☐ Yes ☐ No
If yes, provide date(s):

Hire date

Work frequency
☐ Permanent full-time ☐ Permanent part-time ☐ Seasonal ☐ Casual
If seasonal or casual, start date: , expected end date:

Work type
☐ Owner-operator
☐ Subcontractor
☐ Piece work (paid by amount produced/ services completed)
☐ Doesn't apply

Does the employee work the same days every week? ☐ Yes ☐ No
If yes, indicate **number** of hours worked each day of the week (example: 7.5) :

M	Tu	W	Th	F	Sa	Su

If no, **average number** of hours per day:
If no, **average number** of days per week:

If employed less than 12 months, gross earnings for period before stopping work: (from to)

Gross weekly earnings (including overtime). If varies, provide average of last four weeks:

Gross earnings for the 12 months immediately before stopping work:

Hourly rate:

Does the employee have a TD1 Married Exemption reported with payroll? ☐ Yes ☐ No

Have you provided the employee any wage replacement (sick, vacation, etc.) beyond the date of injury or illness? ☐ Yes ☐ No

If yes, please provide details:

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6. Declaration and consent

Do you have any objections to your employee receiving workers' compensation benefits for this injury or illness? ☐ Yes ☐ No

If yes, please explain (maximum 2,000 characters). If you need more space, please attach a separate document.

☐ 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* (employer representative)	Date (yyyy-mm-dd)

* Your employee does not sign this report. If the employee chooses to apply for workers' compensation benefits, the worker must complete the *Application for Workers' Compensation Benefits.* Both the employer and worker forms are required to process a claim application.

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7. Submission

Submit your *Employer Report of Injury or Illness* through your secure MyServices account. MyServices also allows you to get clearance certificates, report annual payroll (Form 100), report monthly payroll (MAAP) and more. Learn more.

To submit your report by email, attach the completed document and state "Report of Injury / Illness" in the subject line, then email to app-dem@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

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Instructions

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.

REPORTING A HEARING LOSS-RELATED INJURY OR ILLNESS? Occupational hearing loss claims require additional information to help WorkSafeNB determine if the hearing loss is applicable for coverage under New Brunswick's *Workers' Compensation Act*. If you are reporting an injury or illness related to hearing loss, please complete the Employer Report of Occupational Hearing Loss form rather than this report. Exception: If the employee's hearing loss is a result of a specific event, such as an explosion, please continue to complete this *Employer Report of Injury or Illness* form. Please note, under the *Occupational Health and Safety Act*, you must immediately report any accidental explosion that occurs in the workplace.

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 Guide to OHS Legislation website/app.

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Please have ready:

- 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

Note: Your employee does not sign this report. The worker must complete the Application for Workers' Compensation Benefits to apply for benefits of wage replacement, medical treatment or both. **Both employer and worker forms are required to process a WorkSafeNB claim application.**

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.

Stay connected to your employee

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.).