



TELL US ABOUT YOU

Worker's last name	Worker's first name	Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female
Worker's mailing address _____ _____ _____		Home telephone # ()	
		Work telephone # ()	
		Cell number # ()	
		E-mail address	
Date of birth (d/m/y)	Social insurance #		
Employer's name and address (include government department if applicable) _____ _____ _____		Worker's occupation	
		Name of supervisor	
		Supervisor's telephone # ()	
		Cell number # ()	

TELL US ABOUT YOUR INJURY/ILLNESS

In your own words, what happened? _____ _____ _____			
Part of body injured (indicate left or right)			Have you hurt this part of your body before? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of injury/illness (d/m/y)	If your injury/illness occurred over time, when did you first experience symptoms?		
Who did you report the injury/illness to?		When did you report the injury/illness (d/m/y)?	
What were your hours of work on the day of injury/illness? (from/to)		What equipment was being used?	
Was first aid given at the work site? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you doing work for your employer when the injury/illness occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the injury/illness happen on the employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you seek medical attention beyond first aid at the work site? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, where?		
When?		Who treated you?	
Did you miss work after the date of injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, when (d/m/y)?	

If you have not already done so, you need to report your injury/illness to your employer right away. You can give them a copy of this form.

ABOUT YOUR INFORMATION

I declare that the information provided is true and correct. I consent to the release from any source including the Canada Revenue Agency to the Yukon Workers' Compensation Health and Safety Board (YWCHSB) of any medical or employment information relevant to my claim. I consent to YWCHSB disclosing to healthcare providers, hospitals, physicians, my employers, other workers' compensation boards, Canada Revenue Agency and any other relevant third parties, all relevant information necessary to administer my claim in accordance with the law.

I acknowledge that the YWCHSB may collect information it considers relevant to my claim to determine benefit entitlement and that my social insurance number may be used for reporting to Canada Revenue Agency and collecting information from Canada Revenue Agency for the purpose of determining benefit entitlement in accordance with the law.

Signature _____ Date (d/m/y) _____

This information is being collected under the authority of the *Workers' Compensation Act* for the purpose of determining eligibility for benefits. YWCHSB may obtain and disclose information from this claim, to the employer for the purpose of appeal, or may disclose such information to others in accordance with the law, including the *Workers' Compensation Act*.