

WSBC Information

Today's Date: _____

All information must be completed before submitting this form to our office including your WSBC claim #.
To obtain a WorkSafeBC claim number, please call **1-888-WORKERS (1-888-967-5377)**.

If you do not contact WorkSafe to submit your claim this will result in the refusal of the claim by WorkSafe and possible delay in any benefits that may be claimed.

BE ADVISED: The physician is obligated to report all services related to a work injury. You will be given the option to pursue or cancel your claim when you are contacted by WorkSafe BC.

In the event you do not pursue this claim with WorkSafe it is imperative you call our office and inform us

NOTE: ALL FIELDS ARE MANDATORY

Patient Name: _____

Patient Email: _____

WSBC Claim Number: _____

Date of work injury: day/month/year: _____/_____/_____

Who rendered first treatment (name of doctor or clinic): _____

What did you injure (body part)? _____

Brief description of what occurred: _____

Did you miss work? Y N

Are you doing light/modified duties? Y N

Employer Information all fields mandatory:

Full name of employer: _____

Full address and postal code: _____

Work (Employer) phone number: _____

Contact person: _____