Murrayville Family Practice Group **Willoughby Family Practice Group**

WSBC Information

Today's Date: ____________________

All information must be completed before submitting this form to our office including your WSBC claim #.
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 FULL Name: ____

Patient Email: ____

WSBC Claim Number: ______________________________
NOTE - if you do not have claim number, you must call WorkSafeBC directly to make a claim and inform our office of your claim number immediately. **1-888-WORKERS (1-888-967-5377).**

Date of work injury: day/month/year: ___________/_____________/________________

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

What did you injure (body part)? ____

Is there any previous injury to this body part? If so, when? ____

Brief description of what occurred: ____

Did you miss work? ☐ Y ☐ N From When? ___/____/ 20__
DD MM YYYY

Have you returned to work? ☐ Y ☐ N From When? ___/____/ 20__
DD MM YYYY

Are you doing light/modified duties? ☐ Y ☐ N Are you back to regular duties? ☐ Y ☐ N

Employer Information all fields mandatory:

Full name of employer: ____

Full address and postal code: ____

Work (Employer) phone number: ____

Contact person: ____

Updated: January 9, 2025