WCB ACCIDENT REPORT

WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

HALIFAX:
5668 South Street
PO Box 1150
Halifax, Nova Scotia
B3J 2Y2
Tel: (902) 491-8999
Toll Free: 1-800-870-3331
Fax: (902) 491-8001

SYDNEY:
Medical Arts Building
336 Kings Road, Suite 117
Sydney, Nova Scotia
B1S 1A9
Tel: (902) 563-2444
Toll Free: 1-800-880-0003
Fax: (902) 563-0512

This form must be completed by both the employer and the injured worker and forwarded to the Workers' Compensation Board (WCB) within **FIVE BUSINESS DAYS** of the accident or illness being reported to the employer. Failure to do so could result in penalties being imposed. If, due to the seriousness of the injury, the worker is not able to sign this form, please forward the Accident Report unsigned by the worker. **PLEASE PRINT CLEARLY**. This report is also available as a PDF (Portable Document Format) file which can be downloaded from the WCB website at www.wcb.ns.ca.

EMPLOYER INFORMATION

Cape Breton University — COMPANY NAME
490900 — BUSINESS # (OR FIRM NUMBER)
1250 Grand Lake Road — STREET
Sydney — CITY/TOWN
CONTACT NAME
Nova Scotia — PROVINCE
B1M 1A2 — POSTAL CODE
CONTACT PHONE
(902) 563-1158 — PHONE
(902) 563-1458 — FAX
EMAIL
TRADE NAME (IF DIFFERENT THAN COMPANY NAME)

WORKER INFORMATION

NAME
OCCUPATION
STREET
CITY/TOWN
NS HEALTH CARD #
PROVINCE
POSTAL CODE
SOCIAL INSURANCE # (PLEASE COMPLETE ON ALL PAGES)
MAILING ADDRESS (IF DIFFERENT THAN ABOVE)
DATE OF BIRTH (D/M/Y)
HOME PHONE
WORK PHONE
CELL PHONE
GENDER: ☐ MALE ☐ FEMALE

WCB USE ONLY:

FIRM # / BN
DIV. #
CLIENT ID
CLAIM #
ISU

DECLARATION AND CONSENT

THE WORKERS' COMPENSATION ACT REQUIRES THAT BOTH THE EMPLOYER AND THE WORKER SIGN THIS REPORT. If the worker is not immediately available, the employer should sign and forward to the WCB without the worker's signature. It is unlawful to knowingly submit false or misleading information to the WCB.

EMPLOYER:

_____ I declare that all the information provided by me is true and correct to the best of my knowledge.

OR

_____ I declare that I have reviewed the information provided by the worker, and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the worker.

EMPLOYER'S SIGNATURE
TITLE
PHONE
DATE (D/M/Y)

IT IS UNLAWFUL TO COLLECT FULL EARNINGS REPLACEMENT BENEFITS WHILE WORKING OR CAPABLE OF WORKING. YOU MUST ADVISE WCB OF ANY CHANGE IN YOUR EMPLOYMENT STATUS.

WORKER:

_____ I declare that all the information provided by me is true and correct to the best of my knowledge.

OR

_____ I declare that I have reviewed the information provided by the employer, and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the employer.

This will serve the Workers' Compensation Board as my consent to obtain and distribute any information from MSI / Maritime Medical Care Inc., that the WCB determines is necessary to process this claim.

WORKER'S SIGNATURE
DATE (D/M/Y)

Notice: The WCB may obtain and share any information necessary to process this claim with appropriate health-care professionals and government agencies. Such information may include, but is not necessarily limited to, current and prior medical records, examinations, treatments and income information.