WorkplaceNL

MAIL FORM TO:
146-148 Forest Road
P.O. Box 9000 St. John's NL A1A 3B8

CALL US AT:
709.778.1000
1.800.563.9000

FAX FORM TO:
709.778.1302
1.800.276.5257

VISIT US AT:
workplacenl.ca

Employer's Report of Injury

7

WorkplaceNL firm #

SECTION A - GENERAL INFORMATION

This form must be filed within three days of injury / incident.

1

Trade name | Legal name (If different from trade name)

Mailing address | City / Town | Province | Postal code

Street address (if different) | City / Town

Site name | Site # | Site location

2

Contacts	Name	Phone	Ext#	Fax	E-mail
For wage information					
For details of injury					
For disability, return to work					

3

Worker's last name | First name | Initial | Date of birth (yyyy/mm/dd) | Gender ☐ M ☐ F

Mailing address | Apt. | City/town | Province | Postal code

Home phone | Work phone | Social Insurance Number | MCP

4

Do you regularly employ 20 or more workers? ☐ Yes ☐ No

Is the worker an owner / operator of this business? ☐ Yes ☐ No

How long has this worker been in your employ? ☐ less than 12 months ☐ more than 12 months

Are you employed as part of a government-funded program? ☐ Yes ☐ No

Employment status: ☐ Full-time ☐ Part-time ☐ Contractual ☐ Seasonal ☐ Casual

What date was the worker initially hired? (yyyy/mm/dd)

5

What occupation was the worker performing at the time of the injury / incident?

What are the lifting requirements of this occupation?
☐ < 11 lbs ☐ 11-21 lbs ☐ 22-44 lbs ☐ > 44 lbs

SECTION B - INJURY / INCIDENT INFORMATION

6

Date / time of injury / incident (yyyy/mm/dd) (hh:mm) ☐ AM ☐ PM

Did this injury develop over time without a specific injury / incident? ☐ Yes ☐ No

Date/time injury/incident was reported to employer: (yyyy/mm/dd) (hh:mm) ☐ AM ☐ PM

7

Did this injury / incident occur outside Newfoundland and Labrador? ☐ Yes ☐ No

8

To whom was the injury / incident first reported? | Last name | First name | Occupation at time of injury | Phone

9

What part(s) of the worker's body was affected?

Did the worker seek medical attention? ☐ Yes ☐ No

Did the worker require hospitalization for more than two days? ☐ Yes ☐ No

10

Was the work / activity being done for the purpose of the employer's business? ☐ Yes ☐ No

If *no,* what was the purpose?_____

Did the injury / incident happen on the employer's property or worksite? ☐ Yes ☐ No

Specify where:

11

Describe your understanding of how the injury / incident occurred or condition developed:

12

Was the injury / incident caused by anything listed at right? ☐ Yes ☐ No

If yes, tick applicable:
☐ Motor vehicle accident (e.g., forklift, car, truck, ATV)
☐ Person(s) not employed by the employer
☐ Malfunction of product / equipment
☐ Slip and fall
☐ Other: _____

If *yes* to Question 12, was someone else involved? ☐ Yes (If yes, please specify name and contact information, if available.) ☐ No

Last name	First name	Address	Work phone	Home phone

SECTION C - INJURY / INCIDENT NOTIFICATION

13

Has your occupational health and safety committee and / or representative / designate been notified of the incident / condition? ☐ Yes ☐ No

14

Do you have any objections to this claim? ☐ Yes ☐ No

If yes, please use an additional sheet to explain your objections. Further to Section 73 of the Act, you must providea copy of your objections to WorkplaceNL within 10 days of the claim being reported to you. Also, you must provide the worker with a copy of your objections.

This information is collected under the authority of the Workplace Health, Safety and Compensation Act, 2022 to determine entitlement to benefits and manage your claim.

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Use this form when:

- Your employee has a work-related injury / illness or recurring work-related injury / illness that results in any of the following:
  - medical attention;
  - loss of earnings; and / or
  - lost-time from work.

  This includes injuries or illnesses that occurred over time as well as those caused by a single event.
- If you are a partner, proprietor or independent operator (also referred to as owner/operator on this form), you do not need to complete this form. Instead, you should complete a form 6 – worker's report of injury. Please note that coverage will be extended only when optional personal coverage has been purchased from WorkplaceNL.

Points to remember:

- Complete and accurate information is important so as not to delay processing the claim.
- If you have additional information, attach additional pages noting the worker's name and SIN on each page.
- As per the Workplace Health, Safety and Compensation Act, 2022 the form 7 must be forwarded to WorkplaceNL within three days of the injury.

Section A General Information

How long has this worker been in your employ?

- Workers hired for one year or more before the injury are considered continuously employed unless the year was interrupted by a work cessation that ended the employment relationship. For seasonal workers, periods of unemployment are not considered work cessation. For example, if you employed the worker for three years except for a seasonal period of five months per year, this worker is considered to be in your employ for more than 12 months, even if the months are not consecutive.

What date was the worker initially hired?

- This refers to the date the worker became your employee. If the worker has been hired in the past as a seasonal or temporary worker, record the most recent hire date.

What occupation was the worker performing at the time of the work injury / incident?

- In some cases, this may not be the worker's regular job. For example, if the worker's normal job is a welder, but he/she was temporarily working as a shipper / receiver when injured, shipper / receiver would be the occupation at the time of the injury/incident.

Section B – Injury / Incident Information

Did this injury develop over time without a specific injury / incident?

- If the worker is unable to recall when the injury / incident occurred or pain started, and there is no identifiable event, the injury may have developed over time. The worker may report discomfort performing their normal duties (e.g., full-time cashier continually scanning products with the left arm and begins to experience pain in the left elbow). However, if the worker is able to say when their symptoms began, note this date on the form.

Did the injury / incident happen on the employer's property or worksite?

- Detailed information as to where the injury / incident happened is important to process the claim. For example, if on your premises, where did it occur? The shipping area, paint shop or warehouse? If not, where did it happen? For example, you operate a cleaning company and your employee was working at a retail store when the injury happened. In this case, note the name and location of the store.

Describe your understanding of how the injury / incident occurred or condition developed.

- Detailed information about how the injury / incident happened and what the worker was doing when it occurred is important to process the claim. This may include information such as: sizes, weights and names of objects involved; a description of any machinery, tools or vehicles used at the time of the injury/incident; any environmental conditions (work area, temperature, noise, chemicals, gas, fumes); if another person was involved; or any information you think is important.

  For example: “Bob was moving boxes in the storage room. He lifted a 40-pound box from the floor to put on a shelf. He twisted to the right while lifting, and hurt his upper back.”

- If the condition developed over time, provide a description of the worker’s duties. Explain how often he / she performs a particular task; the sizes and weights of objects involved; how long he / she has been doing this work; if there have been any recent changes to the schedule and / or tools or products he / she uses.

Additional information on WorkplaceNL's access, release and protection of your information can be found in Policy GP-01: “Information Protection, Access and Disclosure,” available at **www.workplacenl.ca** or by calling WorkplaceNL's Information Officers at **1.800.563.9000**. Co-ordinator at 1-800-563-9000.

Worker's name | Social Insurance Number

SECTION D - RETURN-TO-WORK INFORMATION

15 Did the worker stop working after the day of injury? ☐ No ☐ Yes

If so, when? yyyy/mm/dd hh:mm ☐ AM ☐ PM

Has the worker since returned to work? ☐ No ☐ Yes

If so, when? yyyy/mm/dd hh:mm ☐ AM ☐ PM

What is the worker's current return-to-work status?

- ◯ Returned to pre-injury job with no changes
- ◯ Returned to pre-injury job with duties only changed
- ◯ Returned to pre-injury job with hours only changed
- ◯ Returned to pre-injury job with duties and hours changed
- ◯ Returned to work in a different job to accommodate injury
- ◯ Other accommodations *specify* _____

Has the worker since been offered modified duties? ☐ Yes ☐ No

16 Has an early and safe return-to-work (ESRTW) plan been completed? ☐ Yes ☐ No Attach plan or forward within five days

SECTION E - EARNINGS INFORMATION Complete only if claim involves lost-time / ESRTW greater than the day of injury.

17 If the worker has not returned to work in any capacity, are you continuing to pay the worker directly during the lost-time period? ☐ Yes ☐ No

The employer must pay worker for day of injury.

Provide date worker stopped receiving wages: yyyy/mm/dd

Are you paying 85% of net? ☐ Yes ☐ No

The employer cannot pay the worker an amount in excess of compensation entitlement.

18 Showing separately for each week or pay period, indicate the worker's gross wages for the four pay periods before lost-time or ESRTW:

include bonuses, overtime, and periods without pay

	Period from			To			Wages		Lost-time					
	yyyy	mm	dd	yyyy	mm	dd	$	¢	Holidays without pay		Illness without pay		Lack of work	
1.										Days		Days		Days
2.										Days		Days		Days
3.										Days		Days		Days
4.										Days		Days		Days

19 Worker's regular hourly rate: _____ Next pay day yyyy/mm/dd Frequency of pay: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-monthly

20 Indicate on this 14-day chart the hours per day the worker would work:

		Sun	Mon	Tue	Wed	Thur	Fri	Sat
1.	Week 1							
2.	Week 2							

If the worker is a shift worker, how many shifts did they lose as a result of the injury / incident? _____

SECTION F - FISHER'S INFORMATION To be completed by master, owner or part owner of a fishing vessel.

21 Vessel name | Vessel length (feet) | Is the worker an owner or part owner of the vessel? ☐ Yes ☐ No

22 Master's name | Master's phone | Master's mailing address | City/Town | Province | Postal code

23 Are the worker's earnings based on a share of the catch? ☐ Yes If yes, describe the worker's share arrangement: _____ ☐ No

	Fish buyer's information If you need more space, please use an additional sheet.					
	Name	Phone	Fax	Gross sales	Start of fishing period yyyy/mm/dd	End of fishing period yyyy/mm/dd
1.						
2.						
3.						

Attach pay stubs or other verification from the fish buyer, if available.

SECTION G - INFORMATION ACCESS AUTHORIZATION

24 If you would like to authorize an individual outside of your organization/company to act on your behalf and access employer information concerning this claim, please submit a completed Form 13, Authorized Representative Form.

SECTION H - SIGNATURE, CONSENT AND DECLARATION

25 I declare this form to be complete and correct. I understand that giving false information or omitting relevant information is a serious offence.

Name *please print*	Position	Signature	Phone	Date yyyy/mm/dd

SECTION I - CO-OPERATION AND OBLIGATION

This form must be filed within three days of the injury • Late and incomplete reports may result in a fine • All employers and workers must co-operate in early and safe return to work • A re-employment obligation may exist if there are 20 or more workers in your employment and if you continuously employed the injured worker for more than one year • The Occupational Health and Safety Act requires that all incidents resulting in serious injury be reported to the Occupational Health and Safety Branch at 709.729.4444.

WorkplaceNL USE ONLY

If attaching additional information, put the worker's first name, last name and Social Insurance Number at the top of each sheet.

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Additional Employer Information

Early and safe return-to-work

The goal of early and safe return to work is to safely return the worker to employment or employability that is comparable to the pre-injury level as soon as possible. With effective return-to-work planning, the human and financial costs associated with a workplace injury are significantly reduced.

Employers and workers are obligated to co-operate in the worker's early and safe return to suitable and available employment with the injury employer. This may involve modified work, ease back to regular work, transfer to an alternate job, or trial work to assess the worker's capability.

Re-employment obligation

Employers who have a legislative duty to modify the workplace in order to accommodate the injured worker's return to the workplace are obligated to do so to the extent that it does not cause undue hardship for the employer. This may include work site/job modification or on-the-job skills development for alternate work.

Finding the right duties

When identifying early and safe return-to-work opportunities with your employee, the first priority should be to maintain the connection to the pre-injury job at some level. Where this is not possible, it is important to work with your employee to identify suitable and available employment that is within your employee's physical capabilities. If you and your employee require any assistance during this process, you should contact your case manager.

Documenting a plan

Once you and your employee have identified suitable job duties that are in keeping with your employee's abilities, you will complete an early and safe return-to-work plan that outlines the agreed upon schedule and progression of duties. If any change occurs to this plan, you must immediately notify your case manager.

Your early and safe return-to-work plan should also outline the scheduled hours and the hourly wage earned. This information will then be used to determine if there is any entitlement to compensation during your return-to-work process.

Employers' role in occupational health and safety

- Ensure the health, safety and welfare of workers and those not in your employ;
- Maintain a healthy and safe workplace, systems, equipment, and tools;
- Provide operating instruction for the use of devices/equipment;
- Ensure workers are aware of hazards;
- Establish an OHS committee/worker health and safety representative/workplace health and safety designate as required and consult/ co-operate with them;
- Respond in writing to recommendations of the OHS committee / worker health and safety representative / workplace health and safety designate and provide them with periodic written updates on implementation;
- Make arrangements for and consult with the OH&S committee / worker health and safety representative / workplace health and safety designate during workplace inspections;
- Co-operate with anyone exercising a duty imposed under OHS legislation;
- Ensure safety clothing/equipment/devices are used;
- Ensure safety procedures are followed at all times; and
- Notify the Assistant Deputy Minister responsible for OHS in the provincial government of a workplace accident that results in, or has the potential to result in, a serious injury or fatality.