WorkplaceNL

SEND BY FAX ONLY
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f 1.800.276.5257

CONTACT US AT:
t 709.778.1000
t 1.800.563.9000

VISIT US AT:
workplacenl.ca

Employer's Fatality Report

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

7FR

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

WorkplaceNL firm #

SECTION A - GENERAL INFORMATION

EMPLOYER

1 Trade name | Legal name *If different from trade name* | Street address and town

Mailing address | Province | Postal code | Site name | Site # | Site location

2

Contacts	Name	Telephone	Fax	E-mail
For wage information				
For details of injury				

WORKER

3 Worker's last name | First name | Initial

Mailing address | Province | Postal code

Street address *(if different)* | Province | Postal code

Contact person for family | Home telephone | Work telephone

4 Social Insurance Number | Date of birth yyyy/mm/dd | Gender Male ☐ Female ☐

5 Was the worker an owner / operator of this business? ☐ Yes ☐ No | Was the worker employed as part of a HRSDC Program? ☐ Yes ☐ No | What occupation was the worker performing at the time of work injury / incident? _____

6 Indicate the personal income tax credits you are claiming:

- ☐ a. Basic personal amount
- ☐ b. Full equivalent to spouse amount (If not full amount, then d. applies)
- ☐ c. Number of children under age 18 you are claiming who are not included in the deduction in item b. above _____
- ☐ d. Other (complete a new TD1 and TD1NL available from Canada Revenue Agency at *www.cra.gc.ca*).

If nothing is indicated above, you will be assumed as (a) basic personal amount.

SECTION B - INJURY / INCIDENT INFORMATION

7 Date / time of injury / incident yyyy/mm/dd hh:mm ☐ AM ☐ PM | Date / time injury / incident was reported to employer yyyy/mm/dd hh:mm ☐ AM ☐ PM | Date of fatality yyyy/mm/dd

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

9 To whom was the injury / incident first reported? | Last name | First name | Occupation | Telephone

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 Were there any witnesses to this injury / incident? ☐ Yes *If yes, specify their name and contact information, if available.* ☐ No

	Last name	First name	Address	Work telephone	Home telephone
1.					
2.					

12 Describe your understanding of how the injury incident causing fatality occurred:

13 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 13, was someone else involved? ☐ Yes *If yes, specify their name and contact information, if available.* ☐ No

	Last name	First name	Address	Work telephone	Home telephone
1.					
2.					

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Worker's name	Social Insurance Number

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

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

If yes, please use an additional sheet to explain your objections. Further to Section 63 of the WHSC Act, you must provide a 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.

SECTION C - EARNINGS INFORMATION

Complete this section if the date of fatality is different than the date of injury / incident.

16 Showing separately for each week or pay period, indicate the worker's gross wages for the pay periods prior to the injury / incident: *include bonuses, overtime and periods without pay.*

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

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

Worker's regular hourly rate: _____

What were the worker's earnings for the 12 months prior to the date of injury/incident? _____

18 Indicate on this 14-day chart the hours per day the worker would have worked.

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

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

SECTION D - FISHERS' INFORMATION

To be completed by master, owner or part owner of a fishing vessel.

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

20 Master's name | Master's telephone | Master's mailing address | Province | Postal code

21 Was the worker's earnings based on a share of the catch? ☐ Yes *If yes, please specify name and contact information, if available.*

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

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

SECTION E - ADDITIONAL COMMENTS

22 Comments:

SECTION F - INFORMATION ACCESS AUTHORIZATION

23 Do you authorize another individual outside your organization or company to act on your behalf and access employer information regarding this claim? ☐ Yes ☐ No ***This authorization will remain in effect until you notify WorkplaceNL of a change using Form 13.***

Last name	First name	Address	Organization *if applicable*	Telephone

SECTION G - CONSENT AND DECLARATION

24 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	Telephone	Date yyyy/mm/dd

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

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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