

# NOTICE OF INJURY TO EMPLOYER



**IMPORTANT: Do not send this form to the WCB.** Keep one copy for yourself and provide a copy to your employer.

If the workplace incident has resulted in an injury requiring healthcare attention or time off from work, please report the injury to the WCB by calling:

204-954-4100 or toll free 1-855-954-4321 (8:00 AM to 7:00 PM, Monday to Friday)

Injured Worker Name \_\_\_\_\_

Injured Worker Address \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time \_\_\_\_\_  AM  PM

Location of Incident (site address and location on site)

\_\_\_\_\_

Description of Incident

\_\_\_\_\_

\_\_\_\_\_

Description of Injury

\_\_\_\_\_

\_\_\_\_\_

Time Off Work Due to Injury  Yes  No

Names of Witnesses (if any) \_\_\_\_\_

Supervisor Signature \_\_\_\_\_

Injured Worker Signature \_\_\_\_\_

Date \_\_\_\_\_