

WCB Accident Report

Name: _____ Date of injury: _____

Time of injury: _____

Who did you report your injury to at work? _____

Were you treated by first aid attendant at work? Yes ___ No ___

Did you see a medical doctor for this injury? Yes ___ No ___

If yes, what was the Dr's name and date of your appointment? _____

What was the diagnosis? _____

What kind of treatments are you receiving? _____

Name of Adjuster? _____

Describe exactly how you were injured _____

What hurt at the time of your accident?

(Circle or check which ones apply to you)

- | | |
|----------------|-----------------|
| Head | Feet |
| Neck | Mid back |
| Low back | Hips |
| Left shoulder | Right shoulder |
| Left upper arm | Right upper arm |
| Left fore arm | Right fore arm |
| Left knee | Right knee |
| Left ankle | Right ankle |

What hurt today?
