

# FORMS

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***The following forms are samples only. You can access WCB forms at [www.wcbask.com](http://www.wcbask.com) or from the WCB offices.***



Business Phone: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Cellular: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Federal Bus. No.: \_\_\_\_\_  
Provincial Corp. No.: \_\_\_\_\_  
Firm No.: \_\_\_\_\_  
Date form issued: \_\_\_\_\_

Business Name, Address, Postal Code

## EMPLOYER REGISTRATION INFORMATION

Please check above information and make additions or corrections.  
INFORMATION ON THIS FORM IS FOR WORK DONE IN **SASKATCHEWAN ONLY**

1. Is the business:  New  Purchased ... If purchased, when? DD/MM/YYYY from whom? \_\_\_\_\_
2. When did you first hire workers in Saskatchewan? Date: DD/MM/YYYY
3. Name of the legal owner (eg. Incorporated company, partners, proprietor): \_\_\_\_\_

4. Physical address: \_\_\_\_\_
5. Type of business activities (include product or service provided): \_\_\_\_\_

6. Do you hire subcontractors?  No  Yes ... If yes, attach a list, include no. of contracts and contract amount. \_\_\_\_\_
7. Do you work for other companies?  No  Yes ... If yes, provide at least \_\_\_\_\_

8. Payroll Information: 

Do not include amounts over maximum per worker per year	2011 Actual Wages (Max. \$55,000)	2012 Actual Wages (Max. \$55,000)	2012 Actual Wages (Max. \$55,000) estimate (Max. \$59,000)
a) Workers: _____			
b) Directors of limited companies on wages (regular, predetermined amount):			
Name: _____			
Name: _____			
c) Total wages _____			

*This form can be completed online. If you complete it on paper – fax it in to speed processing.*

*Call the WCB if you have questions while completing this form: 1-800-667-7590.*

9. Optional Person(s) on wages: \_\_\_\_\_ (proprietors/spouses, partners/spouses or directors of limited companies). If yes, provide the following information.  
Note that the maximum amount is \$20,800 per individual per year and the minimum amount is \$20,800 per individual per year. At the time of registration, proof of earnings in the form of your most recent T4 or Statement of Financial Affairs is required for all individuals earning more than \$20,800.

Name	Date of Birth	Coverage Amount
_____	<u>DD/MM/YYYY</u>	_____
_____	<u>DD/MM/YYYY</u>	_____
_____	<u>DD/MM/YYYY</u>	_____

10. DECLARATION: I declare that all the information provided is true and correct to the best of my knowledge.  
Signature : \_\_\_\_\_ Date : \_\_\_\_\_  
Name (please print) : \_\_\_\_\_ Title : \_\_\_\_\_





# Employer's Initial Report of Injury

WCB Claim No.:

Reporting Options: (1) WCB Telefile 1-800-787-9288 (2) WEB www.wcbask.com (3) Fax

## Section A: Employer Information

Complete this form as soon as you are aware of the injury.

Type of Business: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
WCB Firm No.: \_\_\_\_\_ Industry Rate Code: \_\_\_\_\_

## Section B

You must complete this form if a worker seeks medical treatment for a work injury.

Specific Division (if applicable): \_\_\_\_\_  
Occupation: \_\_\_\_\_  
 Male  Female

Provide any information you have if you think this may NOT be a work injury.

## Section C: Injury Information

- Injury Date: \_\_\_\_\_ 2. Reported to employer: \_\_\_\_\_
- Area of body injured: \_\_\_\_\_ 5. Name of injured worker: \_\_\_\_\_
- How did the injury happen? \_\_\_\_\_
- Has the employee lost time from work, due to the injury, after the day of injury?  Yes, if "yes", go to question 8.  No; If "no" go to Section E
- First day off due to this injury: \_\_\_\_\_ Time the employee left work: \_\_\_\_\_ : \_\_\_\_\_  am  pm
- Has employee returned to work?  Yes  No If "yes", what was the date the employee returned: \_\_\_\_\_
- Do you have any reason to believe that this is not a work-related incident?  Yes  No If "yes", provide attachment(s) with explanation.

## Section D: Wage and Employment Information

- How is the employee paid? If Regular Salary: Hourly \$ \_\_\_\_\_ per hour, \_\_\_\_\_ hours per week; If Monthly \$ \_\_\_\_\_ per month  
If Non-Regular:  Piecework  Sub-Contractor  Owner/Operator  Casual  Other (explain): \_\_\_\_\_
  - Provide gross earnings for the 12 months preceding first day off work due to injury, starting with the most recent complete pay period. If less than 12 months, show earnings for actual period: Gross earnings \$ \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_
  - Time lost during the gross earning period due to: (a) Unpaid sickness \_\_\_\_\_ days; (b) Prior WCB claims \_\_\_\_\_ days; (c) Lack of work \_\_\_\_\_ days; (d) Other \_\_\_\_\_ days, explain \_\_\_\_\_
  - Normal working hours for employee: From \_\_\_\_\_ : \_\_\_\_\_  am  pm to \_\_\_\_\_ : \_\_\_\_\_  am  pm Shift work involved  Yes  No
  - Does the employee have regular days off?  Yes  No If "Yes", check which days off:  Sun  Mon  Tue  Wed  Thu  Fri  Sat  
If "No", check the days off for the month of the injury, plus one before and one month after first day off due to injury.
- |                            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |    |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----|
|                            | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10                       | 11                       | 12                       | 13                       | 14                       | 15                       | 16                       | 17                       | 18                       | 19                       | 20                       | 21                       | 22                       | 23                       | 24                       | 25                       | 26                       | 27                       | 28                       | 29                       | 30                       | 31 |
| Month Before Injury Period | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |    |
| Month Of The Injury        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |    |
| Month After Injury Period  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |    |
- TD1 Exemptions:  Single  Spouse, If partial provide: Provincial amount \$ \_\_\_\_\_ Federal amount \$ \_\_\_\_\_  
 Other: \$ \_\_\_\_\_ No. Children 18 years or under \_\_\_\_\_
  - Should compensation payments be made to:  Employee, OR  Employer? 18. Will employee be paid for statutory holidays?  Yes  No

## Section E: Declaration

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

Date

Name

Title

Signature





SASKATCHEWAN  
WORKERS'  
COMPENSATION  
BOARD

200 – 1881 Scarth Street  
Regina, SK S4P 4L1

Phone: (306) 787-4370  
Toll Free: 1-800-667-7590  
Fax: (306) 787-4311  
Toll Free Fax: 1-888-844-7773

**W1**

# Worker's Initial Report of Injury

WCB Claim No.:

Reporting Options: (1) WCB Telefile 1-800-787-9288 (2) WEB www.wcbsask.com (3) Fax

## Section A: Worker Information

*Any questions?  
Call WCB Telefile  
at 1-800-787-9288*

Sex:  Male  Female

## Section B: Employer Information

Employer contact person: \_\_\_\_\_

Phone number of contact: \_\_\_\_\_

## Section C: Injury Information

1. Injury Date: \_\_\_\_\_ 2. Reported to employer on: \_\_\_\_\_ 3. Reported to: \_\_\_\_\_  
 4. Province of injury: \_\_\_\_\_ 5. Area of body injured: \_\_\_\_\_  
 6. How did the injury happen: \_\_\_\_\_

*Let us know about  
any other employment  
affected by the injury.*

*For fastest and most  
secure payment – the  
worker should provide  
direct deposit information.*

7. Name of employer: \_\_\_\_\_  
 8. Name of supervisor: \_\_\_\_\_  
 9. Have you had any other employment since the day of injury?  Yes...If "yes" go to Section D  No...if "no" go to Section F

## Section D: Employment Information

10. First day of work: \_\_\_\_\_ The time you left work: \_\_\_\_\_  
 11. Have you returned to work? \_\_\_\_\_ If "yes"...enter the date you returned: \_\_\_\_\_  
 12. How many hours per week? \_\_\_\_\_ per hour, \_\_\_\_\_ hours per week  
 If Not Working:  Owner/Operator  Casual  Other  
 13. If you have regular days off, check which days.  Sun  Mon  Tue  Wed  Thu  Fri  Sat  
 14. Do you have other sources of employment income?  Yes  No If "yes"...attach  
 15. Will you be paid by your employer for time loss due to injury?  Yes  No

## Section E: Direct Deposit Information

If you wish to have compensation payments made directly to your bank account, please complete Part 1 of the slip marked "VOID" OR complete Part 2 from your cheque. The Workers' Compensation Board is authorized to provide direct deposit information to the financial institution you have named.

Part 1

Bank or Financial Institution

Branch Address

City

Part 2

Cheque Number (3-digit number)	Transit Number (5-digit number)	Bank Number (3-digit number)	Account Number (Maximum 12-digit number)
NOT REQUIRED			

## Section F: Declaration

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

Date

Name

Signature





SASKATCHEWAN  
WORKERS'  
COMPENSATION  
BOARD

200 - 1881 Scarth Street  
Regina, Sask. S4P 4L1  
Phone: (306) 787-4370  
Toll Free: 1-800-667-7590  
Fax: (306) 787-4311  
Toll Free Fax: 1-888-844-7773

# Employer's Progress Report

# E5

## Section A: Employer Information

Name, address, postal code

Business

WCB

To

1. Type or print using ink.
2. Be accurate and provide all information requested.
3. Ensure you date and sign the declaration at bottom.
4. Attach additional information, if relevant.
5. Mail OR fax report to WCB, keep copy for your own records.
6. Contact the WCB if you have any questions.

*The WCB will send you this form monthly if you have an injured worker who is away from work.*

Claim Information WCB Claim No.:

## Section B: Employee Information

Name, address, postal code

Injury Date: \_\_\_\_\_  
Day Month Year

Area of Injury: \_\_\_\_\_

## Section C: Complete either Portion A or B

### A. The Employee has Returned to Work

1. Date returned: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
Day Month Year
2. Is the employee doing the same job as before the injury?  Yes  No, explain:  
\_\_\_\_\_  
\_\_\_\_\_
3. Is the employee earning the same amount now as before the injury?  
 Yes  No, now earning \$ \_\_\_\_\_ (hour/week/month)
4. Did the employee work between the day of injury and the day they returned to work?  No  Yes, give dates:  
\_\_\_\_\_  
\_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
\_\_\_\_\_  
\_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.
5. Did you pay the employee anything for the period of work?  
 Yes, amount \$ \_\_\_\_\_  No, reason \_\_\_\_\_

### B. The Employee has NOT Returned to Work

1. Have you discussed a Return-to-Work plan with this employee?  Yes  No
2. Is the employee expected to return to work?  No  Yes, when  
Date: \_\_\_\_\_  p.m.
3. Will the re \_\_\_\_\_ explain:  
\_\_\_\_\_
4. Will the re \_\_\_\_\_  
 No
5. Has the employee worked between the day of injury and date of this report?  
 No  Yes, give dates:  
From: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
Day Month Year  
To: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
Day Month Year
6. Did you pay the employee anything for the period worked?  
Yes, amount \$ \_\_\_\_\_ No, reason \_\_\_\_\_

*The injured worker will receive a Worker's Progress Report (W3).*

I declare all the information provided is true and correct. I understand that criminal prosecution may result from any attempt to (1) obtain compensation benefits by fraudulent means and (2) prevent collection of compensation benefits.

Date: \_\_\_\_\_ Title: \_\_\_\_\_ Signature: \_\_\_\_\_

**WorkSafe**  
SASKATCHEWAN

Work to live.



# Medical Restrictions Form HCP-1

## Health Care Practitioner Information:

This company recognizes that the provision of alternate or modified work is important in the prevention of disability and has established a Return-to-Work Program for employees who are unable to perform any or all of their normal duties as a consequence of an injury/illness.

The purpose of this form is to enable the worker to return to alternate work.

We require this information to ensure the worker is safe.

Any work assignments will be off

If we are unable to offer alternate work.

Please provide the work restrictions (i.e. no lifting

It is expected that all restrictions

*Provide this form to your injured worker before appointments to any HCP who may have tips for RTW:*

- *physician*
- *physical therapist*
- *chiropractor*
- *occupational therapist, or*
- *psychologist.*

*An injured worker's HCP may repeat this form before the RTW is complete.*

## Worker Instructions:

- Report injuries and absences for medical reasons to your supervisor immediately
- Obtain medical treatment
- Have your health care practitioner complete the medical restrictions form (on back) during your initial visit to provide you with your restrictions

### **If medical restrictions do not affect your ability to do your job:**

- Return to work for your next scheduled shift
- If medical restrictions affect your ability to do your job:
- Call your supervisor as soon as possible to let him/her know that you are unable to do your job
- At your RTW planning meeting you will be provided (if possible) with alternate work assignments and restrictions as outlined on the medical restrictions form. The alternate work assignments will be off

- honour your current medical restrictions
- be modified if and/or when your medical restrictions change
- allow time for further diagnostic and/or treatment appointments

- Have your health care practitioner complete another medical restrictions form during any follow-up appointments if your medical restrictions change

*The WCB does not pay for completion of this form, but some HCPs may charge for it. If they do, you, the employer will have to pay for it.*

Company Name and Address:

### Medical Restrictions Form

The purpose of this form is to verify injury/illness and to provide restrictions to the employer in order to enable the worker to return to *alternate or modified work* as soon as possible.

The employer requires this information in order to identify suitable work that is both productive and safe.

Any work assignments will honour the outlined restrictions.

If the employer is unable to offer work that is appropriate to the outlined restrictions the worker will be off work.

Please complete and give to worker for delivery to the employer.

Worker's Name:

Due to injury/illness the following restrictions currently apply:

*This form MUST  
be kept confidential!*

Expected duration of restrictions:

<7days    8-14 days    15-21 days    >21 days

Practitioner Name and Signature	Date



**Saskatchewan**  
 Workers'  
 Compensation  
 Board  
 200 - 1881 Scarth Street, Regina, SK S4P 4L1  
 Phone: (306) 787-4370 Toll Free: 1-800-667-7590  
 Fax: (306) 787-4205 Toll Free: 1-877-220-1671  
 Website: www.wcbsask.com

**EMPLOYER'S PAYROLL STATEMENT (EPS)  
 2013-2014**



*Submit your EPS  
 online using Fast  
 File or your online  
 business account at  
 www.wcbsask.com*

Submit your Employer Payroll Statement (EPS) on-line, by going to [www.wcbsask.com](http://www.wcbsask.com)

**The maximum assessable wage rate for 2014 increases from \$55,000 to \$59,000 per employee.**

The attached EPS is used to report your business' actual wages and benefits for the upcoming year so that the WCB can assess your workers' compensation information required is for work completed in **Saskatchewan** on or after January 1, 2014.

**The deadline for return is February 28, 2014.** The EPS must be submitted even if you are no longer operating your business.

Employers who do not return their EPS by the due date will be charged a late filing penalty. This penalty is 5% of the previous year's actual premium plus 5% for each 30 days until the statement is received, to a maximum of 15%. In addition, voluntary or optional personal coverage may be terminated. In cases where the EPS form is not returned or is incomplete, the payroll amount will be estimated on your behalf and you may not be eligible to receive an experience rate discount.

When the actual payroll exceeds the estimated payroll by more than 50%, a 6% Under Estimation Penalty is charged. When the actual payroll is less than 50% of the estimated payroll and the provisional assessment has been paid, a 6% Over Estimation Credit is paid.

**Section 1: Executive Officers of Incorporated Companies on Wages** - Applies to limited/incorporated companies only. "Wages" indicate that you are receiving a predetermined amount on a regular basis (e.g. hourly, weekly, monthly). Wages are *gross* earnings before deductions. If executive officers are on wages, include this amount in Section 2 - Workers' Wages. Do not include more than the maximum assessable amount per executive in this section. The maximum assessable wage is \$55,000 for 2013 and \$59,000 for 2014 .

**Section 2: Workers' Wages** - Applies to all businesses (limited companies, limited partnerships, proprietorships and partnerships) who hire workers. Wages are *gross* earnings before deductions (e.g. salary, hourly rate, commission, casual, sick leave, vacation, bonuses, piecework, etc.) for all your workers. Remember to include any wages for executive officers from Section 1 in this area. Do not include more than the maximum assessable amount per person in this section. The maximum assessable wage amount per person is \$55,000 for 2013 and \$59,000 for 2014 .

**Section 3: Optional Personal Coverage** - Applies to proprietors and their spouses; partners and their spouses; directors of a corporation not on the payroll; elected officials of a city, town or village; and members of the governing body of a non-profit corporation or organization. Annual coverage is available for these individuals in any amount between the minimum and maximum wage amount listed in Section 3 of the form. For coverage amounts above the minimum, proof of earnings (T4 or Statement of Business Activities as supplied to the Canada Revenue Agency) will be requested when your account is assessed.

**Section 4: Contractor Services** - Applies to all businesses in any industry who have hired a person or business to perform work or services on a contract basis. Please include the following details: complete name, address, type of work and amount of contract.



Saskatchewan  
Workers'  
Compensation  
Board

200 - 1881 Scarth Street, Regina, SK S4P 4L1  
Phone: (306) 787-4370 Toll Free: 1-800-667-7590  
Fax: (306) 787-4205 Toll Free: 1-877-220-1671  
Website: www.wcbsask.com

**EMPLOYER'S PAYROLL STATEMENT (EPS)  
2013-2014**

This statement must be returned by **February 28, 2014** to avoid penalties. The information requested is for work completed in **Saskatchewan** only.

*Incorporated companies  
– Don't forget to list the  
executive officers who  
are on your payroll.*

If your name and/or address is different than above, please enter the changes below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Business Name: \_\_\_\_\_  
Fax Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Federal Business #: \_\_\_\_\_

Location of Operations if different than above: \_\_\_\_\_

Have you sold or closed your business?  Yes  No If yes:  Sold  Closed **(Provide details).**

**Section 1: Executive Officers of Incorporated Companies on Wages** - If executive officers are on wages, include this amount in Section 1 and add to Section 2. You will only be assessed once. Do not include more than maximum assessable amount **per person**.  
Maximum Assessable for 2013 - \$55,000  
Maximum Assessable for 2014 - \$59,000

Industry Code	Name(s)	2013 Actual Wages	2014 Estimated Wages

**Section 2: Workers' Wage Information** - Remember to include executive officers wages from Section 1. Do not include more than the maximum assessable amount **per person**. If wages were not paid, enter 0.  
Maximum Assessable for 2013 - \$55,000  
Maximum Assessable for 2014 - \$59,000

Industry Code	Industry Description	2013 Estimated Wages	2013 Rate	2013 Actual Wages	2014 Rate	2014 Estimated Wages

**Section 3: Optional Personal Coverage** - Information proof of earnings will be required for any amount above the minimum. Do not include wages listed in Section 1.  
Minimum - \$20,800 Maximum - \$59,000

Industry Code	2013 Coverage Amount	Continue Coverage for 2014 ?	2014 Coverage Amount
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

*You must include  
the executive officers'  
wages in Sections 1  
AND 2.*

**Section 4: Contractor Services**  
Did you use contractors in 2013?  Yes  No ... If yes, please complete attached Estimate for non-registered contractors: \_\_\_\_\_

**Declaration:** I declare that all the information provided is true and correct to the best of my knowledge.

Signature : \_\_\_\_\_ Date : \_\_\_\_\_  
Name (please print) : \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Accountant Name : \_\_\_\_\_ Phone Number: \_\_\_\_\_

**PLEASE SUBMIT ONLINE, BY FAX OR MAIL**



**Saskatchewan** 200 - 1881 Scarth Street, Regina, SK S4P 4L1  
**Workers'** Phone:(306)787-4370 Toll Free: 1-800-667-7590  
**Compensation** Fax: (306)787-4205 Toll Free: 1-877-220-1671  
**Board** Website: www.wcbask.com

**EMPLOYER'S PAYROLL STATEMENT (EPS)  
2013-2014**

**EPS CONTRACTOR LIST**

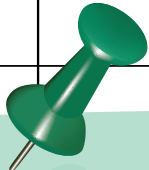
**2013-2014**

Firm Name	Firm

Please return your contractor list with your completed EPS. If additional space is required, please make copies of this form. Contractors listed here should not be included under Section 2 - Workers' Wage Information. Please print clearly to assist us in processing the information.

**Contractors To Be Reported** (where clearances were not obtained). Please provide the information requested.

Contractor WCB Firm # (if known)	CONTRACTOR NAME AND ADDRESS	DESCRIPTION OF WORK PERFORMED	2013 CONTRACT AMOUNT (EXCLUDE GST/PST)	LABOUR PORTION (if known)



*Provide the (sub) contractor's firm number. Not your firm number (top right).*

*Don't forget to include a description of the work.*



**Employer's Request for Photocopy  
of Relevant Records in File(s)**

**ATTENTION: CASE MANAGEMENT REPRESENTATIVE**

Workers' Compensation Board Claim Number(s): \_\_\_\_\_

Injured Worker's Name: \_\_\_\_\_

Date of Decision Being Appealed: \_\_\_\_\_

I request photocopies of the above file(s) on the above claim(s) in which the disputable issue is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand the Board must notify the worker of this request and consi  
has to it.

I confirm that I am the employer or have been duly authorized to repres  
authorization.

In accordance with the provisions of Section 174(1), (2), and (3) of *The  
Board Act, 2013*, I will not use any information contained in the said file  
purpose other than of pursuing the disputable issue with the Workers'

Your request for a copy of the file is NOT a request for an appeal.

Dated this \_\_\_\_\_ day of \_\_\_\_\_

Name: \_\_\_\_\_  
(Please print)

Signed: \_\_\_\_\_

Position/Title: \_\_\_\_\_

*You can only ask  
for a worker's file  
if you have a  
disputable and  
appealable issue.  
You will only  
receive information  
regarding your  
disputable issue.*



**Authorization  
Letter of Representation**

I, \_\_\_\_\_  
(print name in full)

authorize Mr.

Ms.

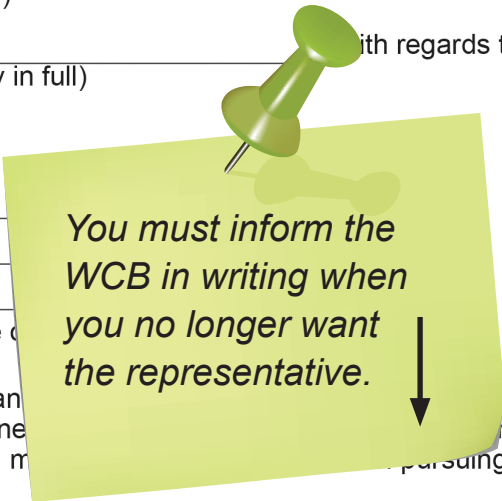
Mrs.

\_\_\_\_\_ (print name in full)

to represent \_\_\_\_\_ with regards to  
(print name of company in full)

the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (indicate specific issue)



In accordance with the provisions of Section 174(1),(2), and Section 175(1) of the Workers' Compensation Act, 2013, my representative will not use information contained in this document for any purpose other than reconsideration or review of a decision made by the Board in pursuing a disputable issue with the Workers' Compensation Board.

This letter of representation will remain in full force and effect until such time as I notify the Workers' Compensation Board in writing that I no longer wish the individual named above to act as my representative.

Signed and witnessed at \_\_\_\_\_, in the Province of \_\_\_\_\_

on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

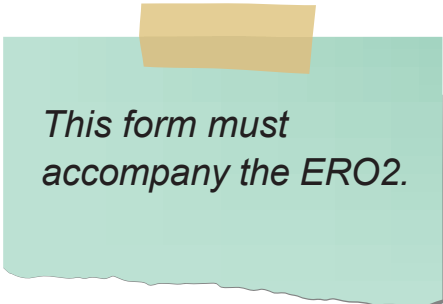
Firm Name and Number: \_\_\_\_\_  
(print in full)

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness\* \_\_\_\_\_  
(print name in full)

\_\_\_\_\_  
(Signature)



\* = Someone other than the person being designated as the representative



**Employer's Representative's  
Request for Photocopy of File(s)**

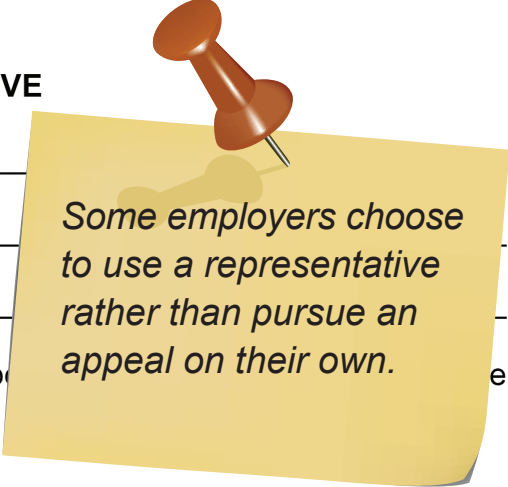
**ATTENTION: CLIENT SERVICE REPRESENTATIVE**

Workers' Compensation Board Claim number(s) \_\_\_\_\_

Injured Worker's Name \_\_\_\_\_

Date of Decision Being Appealed \_\_\_\_\_

I request photocopies of the above file(s) on the above  
issue is:



*Some employers choose to use a representative rather than pursue an appeal on their own.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I confirm that I have been duly authorized to do so and to represent \_\_\_\_\_

\_\_\_\_\_, as per attached authorization.

I understand the Board must notify the worker of this request and consider any objections he has to it.

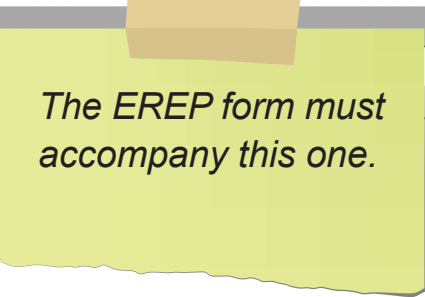
In accordance with the provisions of Section 174(1) of The Workers' Compensation Act, 2013, I will not use any information contained in the said file(s) publicly or for any purpose other than of pursuing the disputable issue with the Workers' Compensation Board.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

Signed \_\_\_\_\_  
Please print & sign form before mailing/faxing.

Position/Title \_\_\_\_\_

Address \_\_\_\_\_



*The EREP form must accompany this one.*



## Job Information Worksheet

Please ensure this form is completed as fully as possible by the worker's immediate supervisor and the worker (if available).

Questions? Contact the WCB toll free in Saskatchewan 1-800-667-7590. In Regina 787-4370.

Worker's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Worker's Position Title: \_\_\_\_\_ Occupation: \_\_\_\_\_

Other Jobs Employee May Have: \_\_\_\_\_

Employer: \_\_\_\_\_ Signature: \_\_\_\_\_

Employer Address: \_\_\_\_\_

*Both the worker and employer complete this form.*

FOR EMPLOYER & WORKER USE ONLY - Describe actual work activities	
<b>JOB NORMALLY REQUIRES</b>	
<b>SITTING (INCLUDES DRIVING)</b>	
Total number of sitting hours in a shift: <input type="checkbox"/> Less than 1 <input type="checkbox"/> 1 - 2 <input type="checkbox"/> 2 - 3 <input type="checkbox"/> 3 - 4 <input type="checkbox"/> 4 - 5 <input type="checkbox"/> 5 - 6 <input type="checkbox"/> 6 - 7 <input type="checkbox"/> 7 - 8 <input type="checkbox"/> More than 8	Total length of time worker sits before standing: <input type="checkbox"/> Under 30 minutes <input type="checkbox"/> 30 - 60 minutes <input type="checkbox"/> 1 - 2 hours <input type="checkbox"/> 2 - 3 hours <input type="checkbox"/> 3 - 4 hours <input type="checkbox"/> more than 4 hours
<b>ADDITIONAL DESCRIPTION</b> On what kind of seating?	
<b>STANDING</b>	
Total number of standing hours in a shift: <input type="checkbox"/> Less than 1 <input type="checkbox"/> 1 - 2 <input type="checkbox"/> 2 - 3 <input type="checkbox"/> 3 - 4 <input type="checkbox"/> 4 - 5 <input type="checkbox"/> 5 - 6 <input type="checkbox"/> 6 - 7 <input type="checkbox"/> 7 - 8 <input type="checkbox"/> More than 8	<b>ADDITIONAL DESCRIPTION</b> On what kind of surface?
<i>Use the duties performed the day before the injury to help you complete these sections.</i>	
<b>BALANCE</b>	
Special circumstances requiring good balance?	

**JOB NORMALLY REQUIRES**

**WALKING**

Normal distance that must be walked:

How often that distance must be walked during a shift:

What type of surface?

**CLIMBING STAIRS**

How many one-storey flights of stairs (about 13 steps) must be climbed at one time?

How many times in a shift do stairs have to be climbed?

What surface?

**CLIMBING LADDERS**

How high is the normal climb?

How many times in a shift must a ladder be climbed?

Is work done from a ladder? How long at one time?

**KNEELING/CRAWLING/CROUCHING/SQUATTING**

Describe the activity:

Number of times this occurs in a normal shift?

Length of time spent in this position in a single, normal instance?

On what kind of surface?

**LIFTING FROM FLOOR TO WAIST**

How much is normally lifted?

- Less than 4.5 kg (1 - 10 lb)
- Up to 9 kg (11 - 20 lb)
- Up to 22.7 kg (21 - 50 lb)
- More than 22.7 kg (50 lb)

Please state amount lifted: \_\_\_\_\_

How many times during a shift is lifting required?

- < 4.5 kg (1 - 10 lb)    \_\_\_ times
- 4.5 - 9 kg (11 - 20 lb)    \_\_\_ times
- 9 - 22.7 kg (21 - 50 lb)    \_\_\_ times
- > 22.7 kg (50 lb)    \_\_\_ times

Please state amount lifted: \_\_\_\_\_

Nature of lifting:

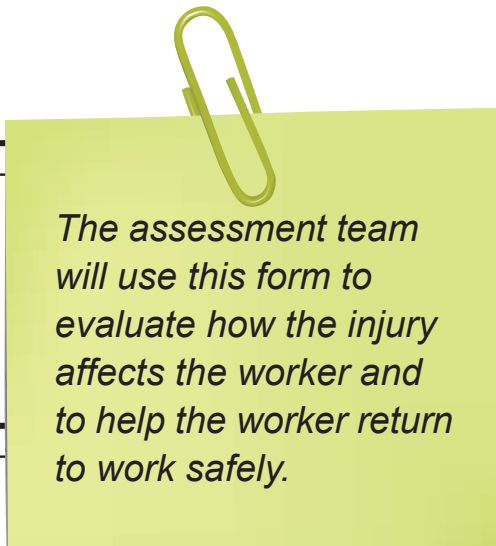
- Independently
- With human assistance
- With mechanical assistance

**ADDITIONAL DESCRIPTION**

What is lifted?

Size of object?

Workstation layout (clear or cluttered aisles, width of space, floor surface, etc.)?



**JOB NORMALLY REQUIRES**

**LIFTING FROM WAIST TO SHOULDER**

How much is normally lifted?

- Less than 4.5 kg (1 - 10 lb)
- Up to 9 kg (11 - 20 lb)
- Up to 22.7 kg (21 - 50 lb)
- More than 22.7 kg (50 lb)

Please state amount lifted: \_\_\_\_\_

How many times during a shift is lifting required?

- < 4.5 kg (1 - 10 lb)    \_\_\_ times
- 4.5 - 9 kg (11 - 20 lb)    \_\_\_ times
- 9 - 22.7 kg (21 - 50 lb)    \_\_\_ times
- > 22.7 kg (50 lb)    \_\_\_ times

Nature of lifting:

- Independently
- With human assistance
- With mechanical assistance

**ADDITIONAL DESCRIPTION**

What is lifted?

Size of object?

Workstation layout (clear or cluttered aisles, width of space, floor surface, etc.)?

**LIFTING ABOVE SHOULDERS**

How much is normally lifted?

- Less than 4.5 kg (1 - 10 lb)
- Up to 9 kg (11 - 20 lb)
- Up to 22.7 kg (21 - 50 lb)
- More than 22.7 kg (50 lb)

Please state amount lifted: \_\_\_\_\_

How many times during a shift is lifting required?

- < 4.5 kg (1 - 10 lb)    \_\_\_ times
- 4.5 - 9 kg (11 - 20 lb)    \_\_\_ times
- 9 - 22.7 kg (21 - 50 lb)    \_\_\_ times
- > 22.7 kg (50 lb)    \_\_\_ times

Nature of lifting:

- Independently
- With human assistance
- With mechanical assistance

**ADDITIONAL DESCRIPTION**

What is lifted?

Size of object?

Workstation layout (clear or cluttered aisles, width of space, floor surface, etc.)?

**CARRYING**

How much is normally carried?

- Less than 4.5 kg (1 - 10 lb)
- Up to 9 kg (11 - 20 lb)
- Up to 22.7 kg (21 - 50 lb)
- More than 22.7 kg (50 lb)

Please state amount carried: \_\_\_\_\_

How many times during a shift is carrying required?

- < 4.5 kg (1 - 10 lb)    \_\_\_ times
- 4.5 - 9 kg (11 - 20 lb)    \_\_\_ times
- 9 - 22.7 kg (21 - 50 lb)    \_\_\_ times
- > 22.7 kg (50 lb)    \_\_\_ times

Nature of carrying:

- Independently
- With human assistance
- With mechanical assistance

**ADDITIONAL DESCRIPTION**

What is carried?

Size of object?

Workstation layout (clear or cluttered aisles, width of space, floor surface, etc.)?

**JOB NORMALLY REQUIRES**

**MOBILE PULLING/PUSHING (OBJECTS ON WHEELS)**

How heavy is the object normally pulled or pushed?

- Less than 4.5 kg (1 - 10 lb)
- Up to 9 kg (11 - 20 lb)
- Up to 22.7 kg (21 - 50 lb)
- More than 22.7 kg (50 lb)

Please state amount pulled or pushed: \_\_\_\_\_

How many times during a shift is pulling or pushing required?

- < 4.5 kg (1 - 10 lb) \_\_\_\_\_ times
- 4.5 - 9 kg (11 - 20 lb) \_\_\_\_\_ times
- 9 - 22.7 kg (21 - 50 lb) \_\_\_\_\_ times
- > 22.7 kg (50 lb) \_\_\_\_\_ times

What is being used to pull/push?

- Trolley     Cart
- Other (specify) \_\_\_\_\_

**ADDITIONAL DESCRIPTION**

What is being pulled or pushed?

Size of object?

How far is the object pulled or pushed?

Workstation layout (clear or cluttered aisles, width of space, floor surface, etc.)?

What surface?

Is the surface:

- level     sloped

**STATIC PULLING/PUSHING (BOXES, LEVERS, PULLEYS)**

How heavy is the object normally pulled or pushed?

- Less than 4.5 kg (1 - 10 lb)
- Up to 9 kg (11 - 20 lb)
- Up to 22.7 kg (21 - 50 lb)
- More than 22.7 kg (50 lb)

Please state amount pulled or pushed: \_\_\_\_\_

How many times during a shift is pulling or pushing required?

- < 4.5 kg (1 - 10 lb) \_\_\_\_\_ times
- 4.5 - 9 kg (11 - 20 lb) \_\_\_\_\_ times
- 9 - 22.7 kg (21 - 50 lb) \_\_\_\_\_ times
- > 22.7 kg (50 lb) \_\_\_\_\_ times

What is being used to pull/push?

- Trolley     Cart
- Other (specify) \_\_\_\_\_

**ADDITIONAL DESCRIPTION**

What is being pulled or pushed?

Size of object?

Height of object: \_\_\_\_\_

How far is the object pulled or pushed?

Workstation layout (clear or cluttered aisles, width of space, floor surface, etc.)?

What surface?

Is the surface:

- level     sloped

**LOW BACK MOVEMENTS (BENDING FORWARD, BENDING BACKWARD, TWISTING)**

This activity involves:

- bending forward
  - how often in a shift? \_\_\_\_\_
  - how long each time? \_\_\_\_\_
- bending backward
  - how often in a shift? \_\_\_\_\_
  - how long each time? \_\_\_\_\_
- twisting
  - how often in a shift? \_\_\_\_\_
  - how long each time? \_\_\_\_\_
- lateral flexation
  - how often in a shift? \_\_\_\_\_
  - how long each time? \_\_\_\_\_

These movements are:

- held more than five minutes at a time
- repeated frequently

Workstation layout (clear or cluttered aisles, width of space, floor surface, etc.)?

These movements are:

- from a seated position
- from a standing position
- from both

**JOB NORMALLY REQUIRES**

**REACHING OVERHEAD**

Is the reach at or beyond full arms length?

yes       no

How long is the reach sustained?

How often does this occur in the most active hour?

How often in a normal shift?

**REACHING FORWARD**

Is the reach at or beyond full arms length?

yes       no

How long is the reach sustained?

How often does this occur in the most active hour?

How often in a normal shift?

Workstation layout:

Height

Depth

Standing

Seated

**NECK MOVEMENTS**

This activity involves:

looking up

- how long at any one time? \_\_\_\_\_

- how often in a busy hour? \_\_\_\_\_

- how often in a normal shift? \_\_\_\_\_

looking down

- how long at any one time? \_\_\_\_\_

- how often in a busy hour? \_\_\_\_\_

- how often in a normal shift? \_\_\_\_\_

looking behind

- how long at any one time? \_\_\_\_\_

- how often in a busy hour? \_\_\_\_\_

- how often in a normal shift? \_\_\_\_\_

rotation

- how long at any one time? \_\_\_\_\_

- how often in a busy hour? \_\_\_\_\_

- how often in a normal shift? \_\_\_\_\_

These neck positions are:

held more than five minutes at a time

repeated, frequent movements

**WORKING WITH HANDS AND FINGERS**

How much time in a normal shift involves this activity?

Less than 1 hour

1 - 2

3 - 4

5 - 6

7 - 8

2 - 3

4 - 5

6 - 7

More than 8

What items are being handled?

What tools, if any, are used?

Circumference of tools?

Workstation layout (height positioning, fumes, heat, etc.)?

**JOB NORMALLY REQUIRES**

**VISUAL ACUITY**

Distance from eyes to object on job?

Describe how vision relates to the job (driving, close or far distances, working with small objects, reading, etc.)

**OPERATING MOTORIZED EQUIPMENT**

How much total time in a normal shift involves operating motorized equipment?

- Less than 1 hour
- 1 - 2
- 2 - 3
- 3 - 4
- 4 - 5
- 5 - 6
- 6 - 7
- 7 - 8
- More than 8

Length of time normally operating equipment before taking a break or changing positions?

- Under 30 minutes
- 30 - 60 minutes
- 1 - 2 hours
- 2 - 3 hours
- 3 - 4 hours
- more than 4 hours

Describe the equipment and work situation.

**SENSITIVITY TO CHEMICAL SUBSTANCES**

What chemicals is the worker exposed to?

Describe the amount of exposure.

What protective apparatus is used, if any?

**WORK ENVIRONMENT**

The work environment involves:

- Outdoors
- Indoors
- Heat
- Cold
- Moisture
- Dryness
- Fumes
- Vibration
- Jarring
- Noise
  - Below 80 decibals
  - Above 80 decibals

Describe the work environment.

**RESTRICTED WORKING HOURS**

How long is a normal shift?

**MENTAL/EMOTIONAL LIMITATIONS**

Describe any significant stresses or emotional aspects of the job.

What services (EAP/EFAP) are available?

**OTHER**

Are there other physical job duties that are expected? (For example: running, throwing, etc.)

If so, how often are these activities required?