DMI
DISABILITY MANAGEMENT INSTITUTE

Employee Injury Report

Instructions for Injured Employees (or Designate) and Their Supervisors

NOTE: Personal information collected on this form is collected for the purposes of generating injury related statistics for the employer and in accordance with the Worker's Compensation Act, the submission of a worker's claim for compensation

Step 1	**Employee** Seek first aid if required. Report your injury to your supervisor	➔	**Employee** Complete the Employee Injury Report Form. Submit the form to Administration and fax a copy of the form to DMI	➔	**Fax** 604-552-3648 or 1-866-963-9994

Step 2	**Administration** Ensure a copy of the completed form has been faxed to DMI	➔	If you have questions call DMI	➔	**Phone** 604-552-3647 or toll free 1-866-963-9994

If you require additional space for comments, please attach a separate sheet of paper and submit with the Employee Injury/Accident Report Form

SECTION A: EMPLOYEE'S REPORT

Please Print

Site / Location			Employer**:**	
Last Name		First Name	Phone	
Address (No, St, Apt)		City/Town	Postal Code	
Birth Date (M/D/Y)		Date of Employment		
Work Phone & Local		SIN (Only if you see a Dr or lose time from work)	Position/Occupation	
Injury Date (M/D/Y)	Time	Date/Time Reported	Reported to	
Describe How and Where the Incident/Accident Happened				
Describe (in detail) Your Injured Body Part (incl. right or left)				
Were you injured? Yes No	Did/will you seek first aid? Yes No	Did/will you see a doctor? Yes No	Doctor/Clinic Name	Did/will you go to Emergency? Yes No
Did you/will you lose time from work beyond the date of injury? Yes No				
Name of Witness:		Name of Supervisor:		

I declare all the information I have given on this report is true and correct. I understand that by completing this form, the Disability Management Institute will submit a "Form 7" in accordance with Worker's Compensation Act and the Occupational Health and Safety Regulations and as such, I elect to claim compensation for the above mentioned injury(s) or disease(s), where said injury or disease has resulted in medical costs or lost time from work. I acknowledge that the WCB may disclose information from my claim to my employer or my employer's authorized agent for the purposes of the management of my claim in accordance with the law including the *Freedom of information and Privacy Act* and *the Personal Information Privacy Act*. I understand it is a serious offense to knowingly make a false claim or to work and earn income while receiving compensation without advising the WCB.

Signature of Injured Employee: Date ______________Month / Day / Year

EMPLOYEE:	MY EMPLOYER HAS TOLD ME MODIFIED WORK IS AVAILABLE.	☐Yes ☐No	**Worker initials** ________	**Date** ________
SUPERVISOR:	I HAVE DISCUSSED MODIFIED WORK WITH THE EMPLOYEE	☐Yes ☐No	**Supervisor Initials** _____	**Date** ________