Name of Injured Person________________________________________ Date of Injury ________________

Department __________________________________ Supervisor Phone #_____________

Location __________________________ Time: ________________ a.m. p.m.

Cause of Injury

What were you doing at the time of Injury?

What was injured? (Please note left or right, if applicable).

Did you report the accident immediately? ___________ To whom? ________________________________

If not what was your reason?

Have you seen or do you plan to see a doctor?
(If you miss work due to an accident, you must see a doctor on the first day you miss work and provide medical updates until you return to work.)

Witness Name __________________________ Phone #____________

Name of Supervisor __________________________ Phone #____________

Signature of Supervisor __________________________ Date___________

Signature of Injured Worker __________________________ Date___________

Distribution:
Supervisor –original
Cc to Employee – copy
Cc to EHSCO -copy Fax 474-7629

Notice of Injury
Form to be completed for all injuries. Worker’s Compensation Employee and Employer Reports should be completed for incidents requiring medical assistance or time loss. Employees may call 954-4100 to report a claim to the WCB. Forms are located on our Web site at: http://www.umanitoba.ca/admin/human_resources/ehso/occ_health_comp/aiwcb.html

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