University of Manitoba

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://umanitoba.ca/admin/vp_admin/risk_management/ehso/occ_health_comp/aiwcb.html

Notice Regarding Collection, Use, and Disclosure of Personal Information and Personal Health Information by the University

Your personal information and personal health information is being collected under the authority of *The University of Manitoba Act*. The information you provide will be used by the University to track all injuries that occur at the University, to determine if a Workers Compensation Board claim is required, and for communication. Your personal information and personal health information may be disclosed to the Worker's Compensation Board in the event of a WCB claim. Your personal information and personal health information will not be used or disclosed for other purposes, unless permitted by *The Personal Health Information Act* (PHIA) or *The Freedom of Information and Protection of Privacy Act* (FIPPA). If you have any questions about the collection of your personal information or personal health information, contact the Access & Privacy Office (tel. 204-474-9462), 233 Elizabeth Dafoe Library, University of Manitoba, Winnipeg, MB, R3T 2N2.

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.)

Name and Address of Doctor:_____

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 EHS – Email copy to: OHReport@Umanitoba.ca or Fax 204-474-7629

Report No._____

Form Updated November 2020