WCB appointments: Please fill out as complete and detailed as possible

Date: _____
Name: _____
Date of Birth: _____
Telephone number: _____
Address: _____
Family Doctor: _____
Date of injury: _____
Time of injury: _____
WCB claim number: _____
Name of Case Manager : _____
Case Manager phone number: _____
Who rendered first treatment: _____

Employer's Info

Employer's name: _____
Employer's address: _____
Employer's phone number: _____

Please circle the correct answer for the following questions.

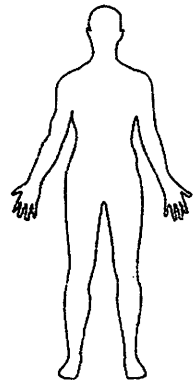
Have you missed any work? Yes No
Have you missed any school? Yes No

Pre-existing problems: _____
_____
_____

Are you taking any medications related to the accident pains? _____
_____
_____

Describe how the accident happened? _____
_____
_____

Shade areas on figure where you were injured?



What normal activities are you now unable to do or have difficulty with as a result of the accident? _____
_____