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EMPLOYER INFORMATION (Please TYPE required information.)

BUSINESS 4: [8 S 8 S 0 9 S 4 0 MW 0 0 0 1		FIRM # [1.0]7 [8 9 7 1 DIVISION # [1 6.	
COMPANY NAME: South Shore Regional School Bd		CONTACT NAME: Stately Sources	
ADDRESS: 130 North Park Street, Bridgewater		CONTACT PHONE: (902) 541-3007	
PROVINCE: NS	POSTAL CODE: 84V 4G9	TIALL: 3508res@ssrsb.ca	
	WORKERS INFORMATION (Pleas	e TYPE required information.)	
NAME		NS HEALTH CARD:	
OCCUPATION:		SOCIAL INSURANCE #:	
ADORESS		DATE OF BIRTHE DATE (METERS/1999)	
CITE/TOWN:			
PROVINCE:	POSTAL CODE:	GENDER O MALE O FEMALE	
HOME PHONE: ()	WORK PHONE: ()	CELL PHONE ()	
WCB USE ONLY:	DECLASATION AND CONCENT (Final a TYPE required information). THE WORKERS' COMPENSATION ACT REQUIRES THAT BOTH THE EMPLOYER AND THE WORKER SIGN THIS REPORT. If the worker is not immediately available, the employer should sign and forward to the WCB without the worker's		
FRIME / BN	signature. It is unlawful to knowingly submit false or mideading information to the WCII. I declare that all the information provided by me is true and correct to the best of my knowledge.		
DEVA	I declare that I have reviewed the information provided by the worker, and I disagree on certain parts. I have attached a separate sheet with my comments and provided a copy to the worker.		
CUENTID	EMPLOYER'S SIGNATURE/TITLE	DATE editionary (1999)	
CLAIM #	PHONE		
rsu	IT IS UNLAWFUL TO COLLECT FULL EARNINGS REPLACEMENT BENEFITS WHILE WORKING OR CAPABLE OF WORKING, YOU MUST ADVISE WCB OF ANY CHANGE IN YOUR EMPLOYMENT STATUS.		
L	- I declare that all the information provide	d by me is true and correct to the best of my knowledge.	
HALIFAX: 5668 South Sevent, PO Box 1 Halfan, Neva Scotta, 832 212	outh Sevent, PO Box 1150 Neves Scotta: 803 27/2 (7)-491-8999 This well serve the Well-Report on Comments and provided by the employer, and I disagree-on-certain parts. I have attached a separate sheet with my comments and provided by the employer. This well serve the Well-Report on Comments to obtain and distribute any information from MSF (2)-491-4901 Marked Blue Comments to obtain the Well-Report on Comments to oppose this claim.		
Tell (902)-691-8999 Fax: (902)-691-8991 Toll Free: 1-800-870-3331			
SYDNEY:			
464 Chuefotte Street, Suite 26		DATE (dd/men/yyyy)	
Sydney, Nova Scotia 81P 162 Telt (902) 563-2444		information necessary to process this claim with appropriate health-care himformation may include, but is not necessarily limited to, current and prior	

When an injury occurs, your first peterity is to ensure your employee gets first aid and medical attention. YOU MUST REPORT ALL INJURIES REQUIRING MEDICAL ATTENTION OR WHERE THE WORKER WILL LOSE TIME FROM WORK. You must also investigate the incident right away to prevent it from happening again.

medical records, examinations, treatments and income information.

This form must be completed by both the employer and the injured worker and forwarded to the Workers' Compensation Board (WCB). Submit this form no more than FWE BUSINESS DAYS after the injury was reported to you. Penalties can apply for late submissions.

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