wcb Saskatchewan Workers' Compensation Board

200 - 1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com

Phone: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free fax: 1.888.844.7773

TXI

Click on any field to start editing.

WCB claim number: ____________________

Worker's name: ____________________

Clinic name: ____________________	Provincial Health Number: ____________________
Clinic number: ________ Care provider number: ________	Date of birth: (MM/DD/YYYY) Phone: ________
Phone: ________ Fax: ________	Employer name: ____________________
Care provider's name, address, postal code	Worker's name, address, postal code

Injury

1. Date of examination: (MM/DD/YYYY) 2. Date of final treatment: (MM/DD/YYYY)
3. Diagnosis:

____

4. History (worker's history of injury including symptoms):

____

5. Clinical findings:

____

6. Describe other conditions not related to the work injury that may affect recovery:

____

7. Functional problems identified (related to work duties):

____

8. Treatment goals (functional abilities required to return to work):

____

9. Treatment plan:

____

10. Worker is currently working: ☐ Yes ☐ No If no, expected return to work date: (MM/DD/YYYY)

11. Date of next appointment: (MM/DD/YYYY) 12. Expected discharge date: (MM/DD/YYYY)

13. Frequency of appointments: ____________________

Signature: Please sign form before mailing/faxing. Date: ________ Copy to: ________

When writing to the WCB, please print name and claim or firm number.