Saskatchewan Workers' Compensation Board

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

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

EMT

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Time loss for medical care

Section A: worker information — to be completed and signed by the employer

Name: ____________________ WCB claim number: ____________

Section B: wage and employment information — complete if no prior time loss paid on this claim

1. (a) If regular salary: Hourly: $ ______ per hour, ______ hours per week (b) If monthly: $ ______ Hourly: $ ______

2. (a) If non-regular: ☐ Piecework ☐ Contractor ☐ Owner/operator ☐ Casual ☐ Other (explain) ____________

   (b) Provide gross earnings for the 12 months preceding the first day off work due to injury, starting with the most recent complete pay period. If less than 12 months, show earnings for the actual period.

   Gross earnings $ ______ from: ______ (MM/DD/YYYY) to: ______ (MM/DD/YYYY)

   (c) Lack of work: ______ days; (d) Other: ______ days, explain: ____________

3. Does the worker have regular days off? ☐ Yes ☐ No

   If "yes", check which days off: ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

   If "no," check the days off for the month of the injury, plus one before and one month after first day off due to injury.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Month before injury period:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Month of the injury:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Month after injury period:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. TDI exemptions: ☐ Single ☐ Spouse If partial, provide: Provincial amount: $ ______ Federal amount: $ ______

5. Should compensation payments be made to: ☐ Worker, or ☐ Employer

Section C: time loss for medical care

Date (MM/DD/YYYY)	Medical type*	Regular shift hours	Number of hours missed

* Type of medical: specialist, general practitioner (GP), chiropractor, physiotherapist, massage or diagnostics/tests

Section D: Employer declaration

I, as the employer, declare all the information provided is true and correct. I understand that criminal prosecution or penalties may result from any attempt to (1) obtain compensation benefits by fraudulent means and/or (2) prevent collection of compensation benefits.

Please print & sign form before mailing/faxing.

Date: ______ (MM/DD/YYYY) Name: ____________ Signature: ____________ Phone: ____________