Workers' Compensation Board Alberta

PO BOX 2415
EDMONTON, ALBERTA T5J 2S5
FAX: 780-427-5863

Please type or print
(Black ink – press firmly)

WCB PATIENT INTAKE

WCB Claim Number	Time loss ❒ No time loss ❒ From what date:	
Worker's Surname	Given Name	Birth Date (Y/M/D)
Worker's Address	Postal Code	Telephone Number
Personal Health Number	Job Title – Occupation (NOC)	
Employer's Name	Address	Telephone Number
Which practitioner or facility rendered first treatment?		Date (Y/M/D)

Date & Time of Accident: _____ Reported to: _____

Your Job Duties and Responsibilities

1.
2.
3.

Description of Accident

Have you had the same or similar condition in the past? When?

Physical Demands – Check all that apply and describe (duration, distance, weight, etc.)

❒ Lifting	❒ Reaching/Handling
❒ Standing	❒ Speaking/Hearing
❒ Walking	❒ Seeing
❒ Climbing/Balancing	❒ Touching/Tasting/Smelling
❒ Stooping/Crawling	❒ Other

Signature: _____ Date: _____