



Please return this form and the **Work Station Confirmation** form to:
 Work Placement Registration
 Manitoba Education and Training
 1567 Dublin Avenue, Winnipeg R3E 3J5
 Email: tve@gov.mb.ca Fax: 204-948-2344

EMPLOYER'S INCIDENT REPORT

Claim No.	2
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Work Placement Information

Business Name		Address (include branch where applicable)		
City	Province	Postal Code	Firm Number 0050153ED	Telephone No.

Worker Information

Last Name		First Name		
Address			City	
Province	Postal Code	Telephone No.	Date of Birth (dd-mm-yyyy)	
Social Insurance Number		Male <input type="checkbox"/>	Female <input type="checkbox"/>	Job title

Incident Details

Date of Incident (dd-mm-yyyy)	Area (s) of injury
Date Reported to Employer	Name and position of person to whom incident was reported.
Please describe the incident in as much detail as possible. (use separate sheet if necessary)	
City and province where incident occurred.	
If the incident occurred out of province, is the worker's usual place of employment in Manitoba? yes <input type="checkbox"/> no <input type="checkbox"/>	Had the worker been employed outside of Manitoba for 6 months or longer at the time of the incident? yes <input type="checkbox"/> no <input type="checkbox"/>
Did the incident occur on your premises? yes <input type="checkbox"/> no <input type="checkbox"/>	If no, specify name and address of premises where incident happened.

Name and Address of Doctor(s) and/or Hospital(s) who Provided Treatment (if known)

Name	Address
Name	Address

NAME OF SCHOOL : _____

NAME OF PERSON RESPONSIBLE FOR THIS PROGRAM : _____

I certify that the above information is true and complete. I agree to notify the Workers Compensation Board of Manitoba immediately of any changes in circumstances affecting this claim. I understand that the Workers Compensation Act requires me to submit an Employers Incident Report **within 5 days** of notification or awareness of an injury requiring treatment or an absence from work and if I do not do so, penalties may be levied.

X _____
 Signature of Supervising Instructor Title Date (dd-mm-yyyy)

FOR USE BY MANITOBA EDUCATION AND TRAINING	
I certify that the above injured person is a student engaged in an approved Work Placement Program.	
_____	_____
On behalf of Manitoba Education and Training	Date