



Please return this form and the
 Work Station Confirmation form to:
 Work Placement Registration
 Manitoba Education
 1567 Dublin Avenue, Winnipeg MB R3E 3J5
 Fax: 204-948-2344

EMPLOYER'S ACCIDENT REPORT

Claim No.	2
-----------	---

WORK PLACEMENT NAME AND ADDRESS

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	
Social Insurance Number	Male <input type="checkbox"/> Female <input type="checkbox"/>	Job Title		

Accident Details

Date of Accident	Area(s) of Injury
Date Reported to Employer	Name and position of person to whom accident was reported.
Please describe the accident in as much detail as possible. (Use separate sheet if necessary)	
City and province where accident occurred.	
If the accident occurred out of province, is the worker's usual place of employment in Manitoba? <input type="checkbox"/> yes <input type="checkbox"/> no	Had the worker been employed outside of Manitoba for 6 months or longer at the time of the accident? <input type="checkbox"/> yes <input type="checkbox"/> no
Did the accident occur on your premises? <input type="checkbox"/> yes <input type="checkbox"/> no	If no, specify name and address of premises where accident 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 change in circumstances affecting this claim. I understand that the Workers Compensation Act requires me to submit an employers 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

FOR USE BY MANITOBA EDUCATION	
I certify that the above injured person is a student engaged in an approved Work Placement Program.	
_____	_____
for Manitoba Education	Date

Please duplicate as necessary.