# FAX

| | | | |
|---|---|---|---|
| **To:** | WorkSafeBC | **From:** | BARRY Neufeld |
| **Fax:** | 1-888-922-8807 | **Pages:** | 4 |
| **Phone:** | 1-888-922-2768 | **Date:** | 12.12.2013 |
| **Re:** | M2/W2 report of injury | **CC:** | Board Members of M2/W2 Association. |

[x] Urgent  [ ] For Review  [ ] Please Comment  [ ] Please Reply  [ ] Please Recycle

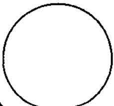
**Comments:**

While Legislation requires that the Employer report a workplace injury within three days, in this case the worker is contracted directly to the board of the organization she works for. It took a few extra days to communicate with all seven board members. The contact in the office is the Administrative Assistant, Luminta Dudas, Ph: (604) 859-3215

Barry Neufeld, CoChair Ph: (604) 798-9425

Darrel Schultz, CoChair Ph: (604) 807-2680

12.12.2013



**HP Officejet Pro 8600 N911n Series**

**Fax Log for**
OCOI Studios
6047939053
13 Dec 2013 7:54AM

## Last Transaction

| Date | Time | Type | Station ID | Duration<br>Digital Fax | Pages | Result |
|---|---|---|---|---|---|---|
| 13 Dec | 7:49AM | Fax Sent | 18889228807 | 2:32<br>N/A | 4 | OK |
| 13 Dec | 7:52AM | Fax Sent | 16048591216 | 2:29<br>N/A | 4 | OK |

WORK SAFE BC
WORKING TO MAKE A DIFFERENCE

# EMPLOYER'S REPORT OF INJURY OR OCCUPATIONAL DISEASE

As an employer, the *Workers Compensation Act* requires you to submit this report **within three days** of an injury to one of your workers, even if you disagree with the claim. By submitting your report promptly, you avoid penalties and delays in the adjudication of the claim. Please report using one of the following options:

1. **Online — The quickest and easiest option**: The online screen application customizes questions to the worker's injury. You can save your report and update it later with new information. Once submitted, you can follow the status of the claim online. Go to **WorkSafeBC.com** and select "Report an injury or illness."
2. **Fillable PDF form**: Type in your details online, print the form, and submit it by **FAX** or **MAIL**. Go to **WorkSafeBC.com** and select "Report an injury or illness."
3. **Paper form**: Clearly PRINT details, sign the form, and submit it by **FAX** or **MAIL**.
   **FAX**: **604 233-9777** in Greater Vancouver or **toll-free** within BC at **1 888 922-8807**
   **MAIL**: WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

WorkSafeBC claim number *(if known)*:

## Employer information

| Field | Value |
|---|---|
| Employer's name *(as registered with WorkSafeBC)* | M2/W2 Association - Restorative Christian Ministries |
| Type of business | Social Services Charity |
| WorkSafeBC account number | 8 7 6 0 7 1 |
| Classification unit number | 766016 |
| Operating location number | |
| Employer address line 1 *(mailing)* | #208 |
| Employer contact last name | Dudas |
| First name | Luminita |
| Employer address line 2 *(mailing)* | 2825 Clearbrook Road |
| Employer contact telephone *(and area code)* | 604-859-3215 |
| Extension | |
| Employer contact fax *(and area code)* | 604-859-1216 |
| City | Abbotsofrd |
| Province/state | BC |
| Employer payroll contact last name | Vetter |
| First name | Al |
| Country *(if not Canada)* | Canada |
| Postal code/zip | V2T 6S3 |
| Employer payroll contact telephone *(and area code)* | 604-859-3215 |
| Extension | |
| Employer payroll contact fax *(and area code)* | 604-859-1216 |

## Worker information

| Field | Value |
|---|---|
| Worker last name | Squires |
| First name | Colette |
| Middle initial | A.L. |
| Gender | M ☐ F ☑ |
| Date of birth *(yyyy-mm-dd)* | 1957-07-10 |
| Home phone number *(include area code)* | 604-309-7319 |
| Social insurance number | 4 5 8 9 9 0 5 2 0 |
| Address line 1 | 3968 Latimer Street |
| Address line 2 | |
| City | Abbotsford |
| Province/state | BC |
| Country *(if not Canada)* | Canada |
| Postal code/zip | V2S 7K7 |

1. What is the worker's occupation? Organizational Consultant on contract
2. Has the worker been employed by this firm for less than 12 months? Yes ☐ No ☑
3. If yes, start date *(yyyy-mm-dd)*
4. At the time of injury, was the worker *(check all that apply)*

Permanent ☐ Temporary ☐ Full time ☐ Part time ☑
Apprentice ☐ Volunteer ☐ Student ☐ New entrant to workforce ☐
Self-employed ☐ Principal/partner or relative of employer ☐ Fisher ☐ Hired on a contract basis ☑
Casual ☐ Other *(please specify)* ☐

## Incident information

5. Date of incident *(yyyy-mm-dd)*: 2013-12-05 Time of incident *(hh:mm)*: 03:20 a.m. ☐ p.m. ☑ **OR**
6. Period of exposure resulting in occupational disease *(yyyy-mm-dd)* From To
7. Did worker report injury or exposure to employer? Yes ☐ No ☐ ▶
8. The injury or disease was first reported to employer on *(yyyy-mm-dd)*
   *(please check one)* To: First aid ☐ Supervisor ☐ Office ☐ Other ☑ *(please specify)* Board Co-chair
9. Name of person reported to: Barry Neufeld (PH: (604) 798-9425)
10. Describe how the incident happened: It began during a Board meeting October 28 when the worker disagreed with the Executive Director. Since then he has escalated his attempts to force her to agree with him, culminating in a degrading personal, verbal attack by his wife against the worker in a public venue Dec 5, 2013, where the worker was representing the organization
11. Describe the injury in detail *(what part of the body was injured)*: Extreme emotional distress and hypertension resulting in severe lower back pain.
12. Side of body injured: Left ☐ Right ☐ Both ☐ Not applicable ☑
13. Describe the work incident location *(address, city, province)* and where incident occurred *(e.g. shop floor, lunchroom, parking lot)*: Conference of Criminal Justice professionals at the University of the Fraser Valley, Clearbrook Centre. Incident occurred in the Foyer, as the delegates were leaving.
14. Did the injury(ies) or exposure result from a specific incident? Yes ☑ No ☐

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# Employer's Report of Injury or Occupational Disease *(continued)*

If faxing form, please complete this section and fax both sides of page. Missing pages may result in delays in processing.

| Worker last name | First name | Middle initial | WorkSafeBC claim number *(if known)* |
|---|---|---|---|
| Squires | Colette | A.L. | |

| Social insurance number | Personal health number *(CareCard)* | Date of incident *(yyyy-mm-dd)* | Date of birth *(yyyy-mm-dd)* |
|---|---|---|---|
| 458990520 | 2147483647 | 2013-12-05 | 1957-07-10 |

15. Contributing factors — select AT LEAST ONE, and as many as applicable

- Lifting ☐ lb ☐ kg ☐
- Overexertion ☐
- Repetitive *(activity repeated over and over again)* ☐
- Slip or trip ☐
- Twist ☐
- Fall ☐
- Struck ☐
- Crush ☐
- Sharp edge ☐
- Fire or explosion ☐
- Harmful substances in the work environment ☐
- Animal bite ☐
- Assault ☐
- Motor vehicle accident ☐
- Unsure/other *(please explain below)* ☑

Public harassment causing emotional distress

16. Were there any witnesses? Yes ☑ No ☐

17. Did the incident occur in British Columbia? Yes ☐ No ☐

18. Were the worker's actions at time of injury for the purpose of your business? Yes ☑ No ☐

19. Did the incident occur on employer's premises or an authorized worksite? Yes ☐ No ☐

20. Did the incident happen during the worker's normal shift? Yes ☑ No ☐

21. Was the worker performing their regular duties at the time of the incident? Yes ☐ No ☐

22. Did the worker receive first aid? Yes ☐ No ☑ Date *(yyyy-mm-dd)* ▶ If yes, please provide first aid attendant name *(if known)*

23. Did the worker go to hospital, clinic, or visit a physician or qualified practitioner? Yes ☑ No ☐ Date *(yyyy-mm-dd)* 2013-12-06 ▶ If yes, please provide provider name *(if known)* Dr. Elmer Raabe, Chiropractor

If yes, please provide provider address *(if known)*
101-2306 McCallum Road, Abbotsford, BC V2S 3P4

24. Are you aware of any recent pain or disability in the area of the worker's reported injury? Yes ☐ No ☑

25. Do you have any objections to the claim being allowed? Yes ☐ No ☑ ▶ If yes, please explain

## Wage information

26. Did the worker miss any time from work beyond the date of injury or exposure? Yes ☐ No ☐

**If NO WORK WAS MISSED and NO CHANGE to duties/pay, proceed to bottom of page to sign, date, and submit this report.**
**If WORK WAS MISSED or if duties/pay have been MODIFIED, please answer ALL questions on this form.**

27. Provide the **base salary** amount for this employment position at the time of injury
$30.22 Hourly ☑ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

28. Does worker receive other amounts of compensation in addition to **base salary**? Yes ☐ No ☑
Does worker receive vacation pay on every cheque? Yes ☐ No ☑
If yes, vacation pay ______%

Please select check boxes for any of the following amounts worker receives in addition to **base salary** AND provide the amount for each:
Tips and gratuities ☐ $______ Room and board ☐ $______
Shift differential ☐ $______ Other ☐ $______
Overtime ☐ $______

29. If worker is disabled from work, will you continue to pay:
**Base salary**? Yes ☑ No ☐
Other amounts of compensation in addition to **base salary**? Yes ☐ No ☑
Will worker receive vacation pay on every cheque? Yes ☐ No ☑
If yes, vacation pay ______%

Please select check boxes for any of the following amounts worker will continue to receive in addition to **base salary** AND provide the amount for each:
Tips and gratuities ☐ $______ Room and board ☐ $______
Shift differential ☐ $______ Other ☐ $______
Overtime ☐ $______

30. Provide the amount of **gross** earnings for the past 3 months or 12 weeks prior to the date of injury or exposure
$11,581.83 3 months ☑ 12 weeks ☐

31. Does the worker have a fixed-shift rotation? Yes ☐ No ☑

32. If no, please explain

33. If yes, show the normal work week by entering the paid hours

| Sun | Mon | Tues | Wed | Thu | Fri | Sat |
|---|---|---|---|---|---|---|
| | | | | | | |

34. Did the worker continue to work past day of injury? Yes ☑ No ☐

35. Last day worked *(yyyy-mm-dd)*

36. Number of hours scheduled to work on last day worked

37. Number of hours worked on last day

38. Number of hours paid by employer on last day worked

![WorkSafeBC logo] WORKSAFE BC
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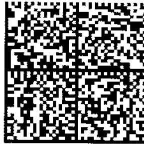

# Employer's Report of Injury or Occupational Disease *(continued)*

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|---|---|---|---|
| Squires | Colette | A.L. | |

| Social insurance number | Personal health number *(CareCard)* | Date of incident *(yyyy-mm-dd)* | Date of birth *(yyyy-mm-dd)* |
|---|---|---|---|
| 458990520 | 2147483647 | 2013-12-05 | 1957-07-10 |

## Return-to-work information

39. Has the worker returned to work?
Yes ☑ No ☐

40. If **YES**: Date *(yyyy-mm-dd)*
Since the return to work, have the worker's duties, hours of work, work schedule, and/or rate of pay changed? Yes ☑ No ☐

41. If **NO**: Do you have any modified or transitional duties available?
Yes ☑ No ☐
Have the modified or transitional duties been offered to the worker? ▶
Yes ☑ No ☐

42. If yes, please describe modified or transitional duties
Worker can work at home, but has been advised by the Board to reduce working hours at the office, to reduce the possibility of future harassment until the situation is resolved

## Signature and report date

| 43. Employer signature | 44. Employer title | 45. Date of report *(yyyy-mm-dd)* |
|---|---|---|
| Barry L Yeanfeld | Co-Chair, Board of Directors | 2013-12-12 |

**For assistance**, please call our Claims Call Centre at 604 231-8888 or toll-free within Canada at 1 888 967-5377.
**Please note**: If you have concerns with this claim, please contact the officer handling the claim at the WorkSafeBC office to make known your objections or you may submit a letter detailing your specific concerns. **Impartial advice on WorkSafeBC claims** — To ensure you have an opportunity to obtain impartial advice on WorkSafeBC claims matters, the BC legislature has provided impartial advisers. **Employers' Advisers** are available to provide independent advice or clarification on a WorkSafeBC claim related to your firm. For additional information on the Employers' Advisers, please refer to their web site at www.labour.gov.bc.ca/eao/.

| **Lower Mainland** | **Kelowna** | **Prince George** | **Victoria** |
|---|---|---|---|
| 604 713-0303 (Richmond) | 250 717-2050 | 250 565-4285 | 250 952-4821 |
| Toll free 1 800 925-2233 | 1 866 855-7575 | 1 888 608-8882 | 1 800 663-8783 |

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.