



GREYSTOKE

Homes & Support Services Inc.

Staff Injury Report Form

Date of injury or illness: _____
Day Month Year

Time: _____ am pm

Date injury or illness reported: _____
Day Month Year

Time: _____ am pm

Full name of injured or ill worker: _____

Description of the injury or illness: _____

Did the injury take place at work? yes no

Description of where the injury or illness occurred/began: _____

Cause of the injury or illness: _____

Treatment Provided: Physician Chiropractic Physiotherapy Other

Explain and provide name of Clinic and Professional providing treatment:

Is this a WCB claim? Yes No

Date WCB contacted _____ Contacted by _____

This form gives the appropriate representative of Greystoke Homes & Support Services Inc. permission to contact the Professional(s) providing treatment should it become necessary.

Staff Signature _____ Date _____

Supervisor Signature _____ Date _____