WCB Job Description Form

Date of Accident: _____

Job Title: _____

Department: _____

Duties and Responsibilities

1.
2.
3.
4.
5.
6.

Working Conditions

Describe the location of this job (indoors, outdoors, underground, scaffold, forest, etc.):
Describe any hazards encountered on this job (heat, rain, radiation, fire, noise, heights, etc.):

Physical Demands:

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

☐ Lifting
☐ Standing
☐ Walking
☐ Climbing/balancing
☐ Stooping/crawling
☐ Reaching/handling
☐ Speaking/hearing
☐ Seeing
☐ Touching/tasting/smelling
☐ Other

Workers' Compensation Board
Alberta

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

Please type or print.
(Black ink - press firmly)

CHIROPRACTOR'S FIRST REPORT

WCB Claim Number		Time loss ☐	No time loss ☐
Worker's Surname	Given Names		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
1. Which practitioner or facility rendered first treatment?			Date (Y M D)