WCB
Workers Compensation
Board of Manitoba

NOTICE OF INJURY

Name of Injured _____

Date of Accident _____ Time: _____ a.m. _____ p.m. _____

Description of Accident _____

_____

_____

What was the Injury? _____

_____

Names of Witnesses to Injury (if any) _____

_____

_____
Signature of Supervisor Reported to

_____
Signature of Injured Worker

_____
Dated

WCB 4106 (06/01)

Note:

Keep one copy for yourself and provide a copy to your employer

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IMPORTANT: Do not send this form to the WCB. If your workplace accident has resulted in an injury requiring treatment by a healthcare professional, please report the accident in the WCB by calling:

954-4100 or toll-free 1-800-362-3340
Monday to Friday
8:00 a.m. to 7:00 p.m.