wcb Workers' Compensation Board – Alberta

C709
ON-SITE HEALTH CENTRE REPORT

Box 2415
Edmonton AB T5J 2S5
Fax: (780) 427-5863
1-800-661-1993

Note: The On-Site Health Centre Report obtains information from on-site health care providers who aren't medical doctors.

WCB Claim Number

Personal Health Number

Social Insurance Number (If no PHN available)

Patient's Surname | First Name | Initial | Date of Birth *(Year / Month / Day)*

Address *Street* | *City/Town* | *Province*

Postal Code | Telephone Number | Job Title/Occupation

Employer Name | Telephone Number:

Address *Street* | *City/Town* | *Province* | Postal Code

1. Name of the Person Giving Treatment | Time of Treatment: | Date of Treatment: *(Year / Month / Day)*

2. Patient's Work Related Injury *(Describe how this injury occurred and any relevant past history)*

Date of Injury: *(Year / Month / Day)*

Part of Body:

3.Patient's Complaint*(nature and site or symptoms)*

4. Referred To Physician: ☐ Yes ☐ No | If yes, whom:

5. Is injury preventing patient from performing date of accident work? ☐ Yes ☐ No | Any permanent impairment anticipated? ☐ Yes ☐ No | Estimated date of return to pre-accident level *(Year / Month / Day)*

6. Can "modified or alternate" work be performed? ☐ Yes ☐ No | Describe work capability:

7. Any work restrictions? ☐ Yes ☐ No | Describe:

8. Provider's Name: (please print) | Professional Designation/ skill code | Provider's Signature

Provider's Address *Street* | *City/Town* | *Province* | *Postal Code*

For whom are you providing this service for: | Date *(Year / Month / Day)* | Telephone Number

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

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