wcb Workers' Compensation Board – Alberta

C709
ON-SITE HEALTH CENTRE REPORT

P.O. 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)	

WORKER DETAILS

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

Address Street	City/Town	Province

Postal Code	Telephone Number	Job Title/Occupation

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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