Person submitting information*	Date of registration* *(yyyy-mm-dd)*	Has the employer been informed of the exposure?*
Worker ❒ Employer ❒ Other ❒		Yes ❒ No ❒ Note

WORKER INFORMATION

* Indicates a mandatory field

Worker's last name*		First name*	
Mailing address line 1*			
Mailing address line 2			City*
Country* Select:	Province/State*	Postal code/Zip*	Phone number *(8:30 a.m.-4:30 p.m.)* *(nnn nnn-nnnn nnnn)*
Gender* Male ❒ Female ❒	Date of birth* *(yyyy-mm-dd)*		Date of hire* *(yyyy-mm)* Instruction
Occupation*			

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EMPLOYER INFORMATION

Firm name*			
Firm number	Employer contact last name	Employer contact first name	
Employer's mailing address line 1			
Employer's mailing address line 2			City*
Country* Select:	Province/State*	Postal code/Zip	Phone number* *(8:30 a.m.-4:30 p.m.)* *(nnn nnn-nnnn nnnn)*
Industry* Select:			
If other (or multiple industries), please specify			

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SUBMITTER INFORMATION (if not the worker or employer)

Last name of contact person*		First name of contact person*	
Organization name			
Mailing address line 1*			
Mailing address line 2			City*
Country* Select:	Province/State*	Postal code/Zip*	Phone number *(8:30 a.m.-4:30 p.m.)* *(nnn nnn-nnnn nnnn)*
Submission on behalf of* Worker ❒ Employer ❒		Has the employer been informed of the exposure?* Yes ❒ No ❒ Note	

If you're a worker or employer, the Submitter Information section will auto-populate. If you need to make changes, please go back to the Worker Information or Employer Information sections.

WORKPLACE EXPOSURE INFORMATION

Work incident location *(address, city, province)* and where incident occurred* *(e.g., shop floor, lunchroom, parking lot)*	
Start date of exposure* *(yyyy-mm-dd)*	End date of exposure* *(yyyy-mm-dd)*
How did the exposure occur?* Select:	If other (or multiple occurrences), please specify
Briefly describe the exposure*	
What was the worker exposed to?* Select:	If other (or multiple exposures), please specify
Was personal protective equipment required?* Yes ❒ No ❒ Unknown ❒	Was personal protective equipment provided?* Yes ❒ No ❒ Unknown ❒
Was personal protective equipment used?* Yes ❒ No ❒ Unknown ❒	**When you're finished completing this form, use the "Validate & save" button below. Once validated and saved, use the "Submit" button.**

Previous | Reset | Print | Validate & save

Submit

WORK SAFE BC

WORKING TO MAKE A DIFFERENCE

Exposure Registry Program

If you have any questions regarding the completion of this form, please contact Prevention Support Services — Prevention Records at 604 276-3231.

Have you been exposed to a harmful substance or agent at work?

If you have, you may be entitled to compensation as set out under section 6 of the *Workers Compensation Act* if you develop an occupational disease due to the exposure — now or in the future.

Due to the latency and long period of exposure required for the onset of some occupational diseases, WorkSafeBC has created this new exposure registry as a way for workers, employers, and others to register a worker's exposure to a harmful substance or agent at work. The information obtained through the registry will be kept as a permanent record of a worker's exposure.

If your exposure has resulted in medical treatment or time loss from work, please complete an application for compensation
Phone 1 888 WORKERS (1 888 967-5377) or #5377 for TELUS, Rogers, and Bell mobility customers, Monday to Friday, 8 a.m. to 4 p.m. PST

To report a serious incident or fatality
Phone 1 888 621-SAFE (7233) Monday to Friday, 8 a.m. to 4 p.m. PST, or toll-free 1 866 WCB-HELP (922-4357) after hours.

I understand the information on this form is collected, used, and disclosed under the authority of the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. I acknowledge that WorkSafeBC may disclose this information to the worker, the employer, or their respective representatives, or to others in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

select one

Person submitting information*

Worker ☐ Employer ☐ Other ☐

** Indicates a mandatory field.*

Next