Employer's Report

of Injury or Occupational Disease

JANUARY 2010

Important Information

How soon should you report injuries to WCB?

- As soon as possible. Research shows the longer the delay in reporting and managing an injury, the higher the claim costs. If you fail to report an injury within 72 hours after receiving notice or knowledge of the injury, you may be penalized up to $25,000.
- Complete and send the attached *Employer's Report* to WCB or if you are a current *myWCB* user report online at www.wcb.ab.ca.
- Provide a copy of the first aid record to your worker.

What injuries should you report to WCB?

- Work-related injuries that cause (or are likely to cause) your worker to be off work beyond the day of the injury.
- Injuries that require modified work beyond the day of the injury.
- Injuries that require medical treatment beyond first aid (e.g., physical therapy, prescription medications, chiropractic).
- Injuries that may result in a permanent disability (e.g., amputations, hearing loss).

What if I have additional information or concerns?

- Send us a letter to help us make a decision about the claim. Check the box in number 4 of the form indicating you have attached a letter. Include names, telephone numbers, and statements of any witnesses.

  Important: If you send a letter, please include your worker's name and Social Insurance Number, your company's name, and your signature.

To report an injury

Electronic: Visit *myWCB Online Services for Employers* at **www.wcb.ab.ca**. Request access online or, if you are a current user, log on to our secure connection with your user ID and password.

Fax: **780-427-5863** (Edmonton) or **1-800-661-1993**
If you fax the report, do not send another copy by mail.

Mail to: WCB, PO Box 2415
Edmonton AB T5J 2S5

Any questions?

Edmonton: **780-498-3999**

Calgary: **403-517-6000**

Toll Free in Alberta: **1-866-922-9221**

Toll Free outside Alberta: **1-800-661-9608**

8 a.m. - 4:30 p.m. Monday through Friday

WCB Workers' Compensation Board Alberta

What happens when your worker is injured at work?

1 Employer

Your worker immediately informs you. You complete and send a form to WCB within 72 hours.

2 Doctor

Your worker sees a doctor about the injury. The doctor completes and sends a form to WCB within 48 hours of your worker's visit.

3 Worker

Your worker completes a *Worker's Report of Injury or Occupational Disease* form and sends it to WCB as soon as possible.

Employer's Report

Doctor's Report

Worker's Report

WCB registers your worker's claim and assigns it to a staff member.

If more information is required to make a decision or if some is missing, WCB will contact you, your worker, or their doctor. ***This causes delays in payment.***

Claim not accepted

The legislative and policy requirements were not met by the information collected. Your worker will be advised of the reason by phone and in writing. They have the option to appeal within one year.

Appeal

Claim accepted

The legislative and policy requirements were met. Benefits and services may include

- Wage loss replacement
- Medical costs
- Case management services
- Return-to-work assistance

Time lost claims

WCB assigns your worker's claim to an **adjudicator** who makes the initial benefit decisions.

If your worker needs additional rehabilitation support to return to work, the claim may be transferred from an adjudicator to a **case manager**.

No time lost claims

Your worker has not missed work past the day of injury, a **claim process team** will monitor their medical treatment.

Teams also review letters and reports for evidence a claim may require adjudication.

Any questions?

Edmonton: 780-498-3999
Calgary: 403-517-6000
Toll Free: 1-866-922-9221

WCB Workers' Compensation Board Alberta

C-040 REV NOV 2010

WCB Workers' Compensation Board Alberta

P.O. BOX 2415
EDMONTON AB T5J 2S5

Phone 780-498-3999 (in Edmonton)
1-866-922-9221 (toll free in Alberta)
1-800-661-9608 (outside Alberta)
Fax 780-427-5863 or 1-800-661-1993

January 2010

EMPLOYER'S REPORT
of Injury or Occupational Disease C040

Seven Digit Claim #:

Claim Type

☐ Time Lost ☐ Modified Work ☐ Fatality — Complete entire report if claim type is one of the above

☐ No Time Lost (Notice of non-disabling injury/illness) — Complete first page only

Worker Information

Last Name:	Former Name: (e.g., maiden name)	First Name:	Initial:
Address:	Apt #:	Social Insurance #:	
City:	Province: Postal Code:	Health Care #: -	Province:
Daytime Phone:	Evening Phone:	Date of Birth: (Year / Month / Day)	Sex: ☐ M ☐ F
Occupation:		Apprentice: ☐ Yes ☐ No	

Employer Information

Business Name or Government Department:	WCB Account Number: Industry:
	Does the injured worker have WCB personal coverage with this business? ☐ Yes ☐ No
Mailing Address:	Is injured worker a proprietor, partner or director in this business? ☐ Yes ☐ No
City:	Employer/Supervisor Contact Name:
Province: Postal Code:	Phone:
Phone: Fax:	E-mail Address:

Injury or Occupational Disease information

1. Date and time of injury: (Year / Month / Day) Time: ☐ a.m. ☐ p.m. ☐ This condition developed over a period of time.

Scheduled hours of employment on the day of accident: From: To:

2. When was someone at your business notified of the injury? (Year / Month / Day) Time: ☐ a.m. ☐ p.m.

Name of person and their position: Contact Information:

3. Did the injury occur on employer's premises? ☐ Yes ☐ No Did injury occur in Alberta? ☐ Yes ☐ No

Location where the accident happened (address or general location):

4. Describe fully, based on the information you have, what happened to cause this injury or disease. Please describe what the worker was doing, including details about any tools, equipment, materials, etc. the worker was using. State any gas, chemicals or extreme temperatures worker may have been exposed to:

If you have more information, please attach a letter. Letter attached? ☐ Yes ☐ No

5. What part of body injured? (hand, eye, back, lungs, etc.) ☐ Left side ☐ Right side

6. What type of injury is this? (sprain, strain, bruise, etc.)

7. Were the worker's actions at the time of injury for the purpose of your business? ☐ Yes ☐ No

8. Were the actions part of the worker's regular duties? ☐ Yes ☐ No

Check the box that best describes the physical demands of the regular duties: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

(See detailed description on page 2 of attached instructions)

9. Indicate type of aid provided: ☐ First aid ☐ Medical aid (Name of treating healthcare professional/hospital): _____ ☐ None

Was a copy of this report given to the injured worker as per the *Workers' Compensation Act*? ☐ Yes ☐ No ☐ Worker declined it

(for office use only)

Employer's Signature: Date: (Year / Month / Day)

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If you have any other information that would help us make a decision, or if you have concerns, please attach a letter.

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

Page 1 of 2

EMPLOYER'S REPORT

Worker's Last Name: | Worker's First Name: | Initial:

Social Insurance #: | Date of Birth: (Year / Month / Day)

Lost Time/Return to Work Information

10 a. Date and time worker first missed work: (Year / Month / Day) Time: ☐ a.m. ☐ p.m.

b. Will/did you pay the worker while off work? ☐ Yes ☐ No

If yes, will/did you pay: ☐ Pre-accident rate of pay and hours of work ☐ Other Rate: $_____ per_____, *or* Number of hours:___ per_____, *or* gross amount: $_____

For the period from: (Year / Month / Day) to (Year / Month / Day)

c. If the worker has returned to work indicate date: (Year / Month / Day) Time: ☐ a.m. ☐ p.m.

Check: ☐ Regular work duties, *or* ☐ Modified work duties ☐ Regular hours of work, *or* ☐ Modified hours of work _____ hrs per _____

☐ Pre-accident rate of pay, *or* ☐ Revised rate of pay $ _____ per _____

d. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? ☐ Yes ☐ No ☐ Was offered but the worker declined

Type of Employment (Complete A or B or C)

11 **A** ☐ Permanent position employed 12 months of the year: ☐ Full-time ☐ Part-time

or **B** ☐ Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs):

☐ Seasonal worker ☐ Temporary position ☐ Casual as needed ☐ Volunteer ☐ Summer student

Had this injury not occurred the worker's last day of employment would have been: (Year / Month / Day) ☐ Estimated *or* ☐ Actual

How many months or days per year do you employ people in this position?

or **C** Special employment circumstance: ☐ Contractor/sub contractor ☐ Vehicle owner/operator ☐ Welder owner/operator ☐ Commission

☐ Piece work ☐ Other/self-employed

Does the worker incur expenses to perform the work (materials, tools, etc.)? ☐ Yes ☐ No Will the worker receive a T4? ☐ Yes ☐ No

Note: If you have checked any box in 11C, have the worker submit a detailed income and expense statement.

Wage Information

Date the worker was hired: (Year / Month / Day)

12 a. Worker's rate of pay at time of accident: $ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other:

b. Additional taxable benefits:

Vacation Pay	☐ Included in rate of pay %:	OR ☐ Taken as time off with pay
Stat Holiday Pay	☐ Included in rate of pay %:	OR ☐ Taken as time off with pay
Shift Premium # 1	☐ Amount: $	→ Paid per:
Shift Premium # 2	☐ Amount: $	→ Paid per:
Regular Overtime	☐ Rate: $	→ Number of hours: per ☐ Week ☐ Month ☐ Shift cycle
Other	☐ Explain:	→ Amount: per ☐ Week ☐ Month ☐ Shift cycle

13 a. Gross earnings for the period of one year or date the worker was hired if less than one year: $ from: (Year / Month / Day) (12 months or less prior) to: (Year / Month / Day) (date of injury)

b. Was any time missed from work without pay during the above period, excluding vacation? (eg. maternity, sick, work shutdown, WCB benefits) ☐ Yes ☐ No

If yes, number of days: Reason:

Hours of Work

14 a. Number of hours (not including overtime): per ☐ Day ☐ Week ☐ Shift cycle ☐ Other:

b. Does the work schedule repeat? ☐ No ☐ Yes → Mark hours worked for one complete work schedule (use zero for days off):

Average hours worked per week: ↓

c. Date shift cycle commenced: (Year / Month / Day)

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day:							
Hours per day:							
Hours per day:							

IMPORTANT: Circle day of injury. See instructions

or If the worker's schedule is more than 21 days, attach a copy of schedule.

Earnings Information Contact (please print): Phone Number:

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Employer's Report Instructions

The numbers refer to question numbers on the form that may require additional explanation.

*If you are unclear or need assistance completing this form, call **780-498-3999**.*

Claim Number

Please provide the seven digit claim number if available.

Claim Type

Time Lost (TL)
Check this box if your worker is off work past the day of the injury. (Complete both pages of the form.)

Modified Work
Check this box if your worker's duties have changed because of the injury. Modified work includes a change in duties, job, hours, or amount of work. If your worker is on modified work beyond the day of the accident, the injury must be reported to WCB even if there is no time lost or loss of earnings. (Complete both pages of the form.)

No Time Lost (NTL)
Check this box if your worker will not miss work beyond the day of the injury. (Complete the first page only of the form.)

Worker Information

Please provide as much information as possible.

Employer Information

Employer contact
Provide the contact name and number of the person in your company managing your worker's claim and return to work.

Injury or Occupational Disease Information

1 Date & time of injury
If the injury/condition or occupational disease developed over a period of time, indicate the date you first became aware of the injury.

2 When was someone notified of the injury?
Name the date, time, person, position and contact information.

3 Location of accident
This information may be needed to determine:

- whether your worker was performing duties in the course of employment, *OR*
- whether the injury occurred due to the negligence of another party.

Provide a street address, if possible, indicate the location (e.g., 25 km east of Edmonton on Highway 16, an oil rig site). If it is a motor vehicle accident, include the direction of travel.

4 Describe what happened to cause the injury
Include typical actions and how often they are repeated on the job (e.g., twisting, typing, pushing, and pulling). If there is any lifting, indicate the weight.

If you need more space than the area provided, please attach a letter.

Example:
Bob walked into our walk-in cooler to get a 50 lb. sack of potatoes. He bent down and picked up the sack, turned to his right to leave. He felt a pull in his lower back and dropped the potatoes on his right foot, also injuring his right foot.

Call the claims contact centre 780-498-3999 or 1-866-922-9221 if you are reporting one of the following:

1. Repetitive strain injury
For example, a typist developed tendonitis in the wrist as a result of job duties. Describe fully what job duties are done each day. Include the time spent at each task.

2. Occupational disease
Describe hearing loss, respiratory problems, etc. due to prolonged exposure to gas, chemicals, loud noises, etc.

3. Motor vehicle accident
Send us a copy of the police report, when available.

8 Physical Demands of the job

Sedentary
- Lifting 10 lbs maximum
- Occasional lifting/carrying
- Primarily sitting, with occasional walking/standing

Light
- Lifting 20 lbs maximum
- Frequent lifting/carrying up to 10 lbs
- May require walking/standing to a significant degree
- May involve sitting with pushing and pulling of arm and or leg controls

Medium
- Lifting 50 lbs maximum
- Frequent lifting/carrying up to 20 lbs
- May involve sitting with pushing and pulling of arm and/or leg controls

Heavy
- Lifting 100 lbs maximum
- Frequent lifting/carrying up to 50 lbs

Very Heavy
- Occasional lifting in excess of 100 lbs
- Frequent lifting/carrying excess of 50 lbs

Reference: The Canadian Classification and Dictionary of Occupations

Page 2 of form

Please fill in your worker's name, Social Insurance Number, and date of birth at the top of the second page in case the pages get separated.

Time Lost/Return to Work Information

10 Please fill out all of the information that applies.

Type of Employment

11 **Complete one of the following A or B or C**

- **Complete A** if your worker works for you 12 months per year.
- **Complete B** if your worker works only part of the year, even though you may call him/her back to work each year. To correctly set the amount of compensation, we need to know the total number of days or months per year you would employ someone doing the same job as the injured worker, even if the work period starts and ends several times.
- **Complete C** if the injured person is a contractor, subcontractor, or does piecework. They must send detailed income and expense information.

Wage Information

12 **b. Additional taxable benefits**

Vacation and statutory holiday pay
Please indicate if your worker is paid holiday and stat pay as an additional percentage on their paycheque (therefore must take these days off without pay) or, these days are included as days off with pay.

Shift premiums
Complete if your worker receives pay in addition to the regular rate of pay (e.g., 50¢ paid per hour for night shift). If your worker receives more than one shift premium (e.g., night premium, weekend premium), complete both shift premium boxes. Attach a list if you have three or more shift premiums.

Regular overtime
Complete only if your worker works regular overtime throughout the year.

Other
Use this if your worker gets any other taxable benefits (e.g., permanent accommodation, company car, northern living allowance).

13 **a. Gross earnings**
Provide the gross earnings for your worker for the one year period prior to the injury (less if they have not worked a full year).

Example:
Your worker was injured on June 4, 2007. Provide gross earnings for the period June 4, 2006 to June 3, 2007. A T4 slip for the previous year is not sufficient. If employment lasts less than one year or worked on a seasonal or casual basis, provide the total gross earnings for the entire period worked prior to the injury.

b. Time missed from work without pay
These are periods your worker missed because of work shutdown, maternity leave, or sick leave without pay. Do not include vacation periods.

Hours of Work

14 **a. Number of Hours**
Indicate the regular hours of work, not including overtime periods.

b. Does work schedule repeat?

If No:
Report the average number of hours worked per week during the year prior to the injury.
DO NOT COMPLETE THE WORK SCHEDULE.

If Yes:
Mark the number of hours worked per day in each of the boxes. Put zero for days off. Explain any codes you use in the boxes (for example, **N**=night, **W**=weekends, **D**=days, **E**=evenings). We need to know at what point in this work schedule your worker was injured to determine the compensation to pay.

See example below.

OR:
If the work schedule longer than **21 calendar days**, attach a copy of the schedule. Circle the day on this work schedule that your worker was injured.

Example: *Your worker worked 8-hour days in the first week and 8-hour nights in the second and third weeks. Your worker was injured on the Wednesday of the second week and was off work for 2 days (Thursday and Friday). Your worker would be paid WCB benefits for 2 days.*

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Hours per day:	8D	8D	8D	8D	0	0	0
Hours per day:	8N	8N	8N	8N	8N	8N	0
Hours per day:	8N	8N	8N	8N	8N	0	0

Important: Circle the day in the work schedule your worker was injured.

WCB Workers' Compensation Board Alberta

PO BOX 2415
EDMONTON AB T5J 2S5
Phone: 780-498-3999 (in Edmonton)
1-866-922-9221 (toll free in Alberta)
Fax: 780-427-5863 or 1-800-661-1993

January 2011

WORKER'S REPORT

of Injury or Occupational Disease C060

Seven Digit Claim #:

Worker Information

Past the day of injury: Have you been off work? ☐ Yes ☐ No

1 Have your work duties been modified? ☐ Yes ☐ No

Last Name: | Former Name: (e.g., Maiden Name) | First Name: | Initial:

Address: | Apt #: | Social Insurance #:

City: | Province: | Postal Code: | Health Care #: | Province:

Daytime Phone: | Evening Phone: | Date of Birth: (Year / Month / Day) | Sex: ☐ M ☐ F

Occupation and job title at time of injury: | Self employed? ☐ Yes ☐ No → If yes, WCB-Alberta account #:

E-mail address: | Apprentice? ☐ Yes ☐ No

Employer Information

2 Business Name or Government Department:

Mailing Address: | Fax:

City: | Province: | Postal Code: | Phone:

Injury or Occupational Disease Information

3 Date and time of injury: (Year / Month / Day) | Time: ☐ a.m. ☐ p.m. **or** ☐ This condition developed over a period of time.

Scheduled hours of employment on the day of accident: From: | To:

4 When was someone at your place of employment notified of your injury? (Year / Month / Day) | Time: ☐ a.m. ☐ p.m.

Name of person and their position: | Phone:

If not reported immediately, give the reason:

Did the injury occur on your employer's premises? ☐ Yes ☐ No | Did the injury occur in Alberta? ☐ Yes ☐ No

5 Location where the accident happened (address or general location):

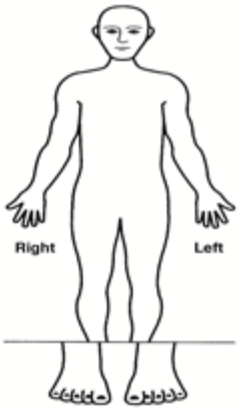
Was the work you were doing for the purpose of your employer's business? ☐ Yes ☐ No | If yes, was it part of your usual work? ☐ Yes ☐ No

6 Please check the box that best describes the physical demands of your work: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy
(see detailed description on page 22 of the Worker Handbook)

What part of your body was injured? (hand, eye, back, lungs, etc.) ☐ Left side ☐ Right side

7 What type of injury is this? (sprain, strain, bruise, etc.)

Circle part injured
Please check: ☐ Front ☐ Back



8 Describe fully what happened to cause this injury or disease. Describe what you were doing and include any tools, equipment, materials, etc. you were using. State any gas, chemicals or extreme temperatures you have been exposed to:

If you have more information or a list of witnesses, please attach a letter. Please check this box if letter attached. ☐

Have you had a similar injury before? ☐ Yes ☐ No **If yes, attach a letter with details.**

Have you reported or claimed this injury to another WCB? ☐ Yes ☐ No If yes, which province or territory?

Full name of treating hospital or healthcare professional:

Address:

Phone: | Date of first medical treatment: (Year / Month / Day)

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Complete all three pages and sign the form before sending.

If your injury is the result of a motor vehicle accident, complete the Motor Vehicle Accident Report (L-054).

WORKER'S REPORT

Your Last Name: First Name: Initial:

Social Insurance #: Date of Birth: (Year / Month / Day) Phone:

Time Lost / Return to Work Information

PLEASE COMPLETE ALL THAT APPLY

9 a. Date and time you first missed work: (Year / Month / Day) Time: ☐ a.m. ☐ p.m.

b. Will/did your employer pay you while off work? ☐ No ☐ Yes, pre-accident wages ☐ Yes, but revised rate: $ _____ per _____

c. Is there any other work you can do until you are medically fit to return to your regular job? ☐ Yes ☐ No

If yes, who can we call to discuss alternate work on your behalf? Phone:

d. If you have not returned to work give the expected return to work date: (Year / Month / Day)

e. If you have returned to work, indicate the date: (Year / Month / Day) Time _____ ☐ a.m. ☐ p.m. ☐ Regular work, or ☐ Modified work

f. If back on modified work, are you: Being paid your pre-accident rate of pay? ☐ Yes ☐ No – provide rate: $ _____ per _____

Working pre-accident hours? ☐ Yes ☐ No – provide hours: _____ per _____

Type of Employment

(Complete A or B or C)

10 A Permanent position employed 12 months of the year: ☐ Permanent full-time ☐ Permanent part-time

or **B** Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs):

☐ Seasonal worker ☐ Temporary position ☐ Casual as needed ☐ Summer student ☐ Volunteer

Had this injury not occurred, your last day of employment would have been: (Year / Month / Day) ☐ Estimated or ☐ Actual

Did you have any other earnings, or income from any other employers, during the last 12 months? ☐ Yes - Please attach copies of pay stubs and/or T4 slips

or **C** Special employment circumstance:

☐ Contractor/sub contractor ☐ Vehicle owner/operator ☐ Welder owner/operator ☐ Commission ☐ Piece work ☐ Other/self-employed

Do you incur expenses to perform the work (materials, tools, etc.)? ☐ Yes ☐ No Will you receive a T4? ☐ Yes ☐ No

Note: If you have checked any box in 12C please submit a detailed income and expense statement.

Wage Information

Date you were hired: (Year / Month / Day)

11 a. Your rate of pay at time of accident: $ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other

b. Additional taxable benefits:

Vacation Pay	☐ Included in rate of pay	%: ☐	OR	☐ Taken as time off with pay	
Stat Holiday Pay	☐ Included in rate of pay	%: ☐	OR	☐ Taken as time off with pay	
Shift Premium #1	☐ Amount: $ ☐	→ Paid per:			
Shift Premium #2	☐ Amount: $ ☐	→ Paid per:			
Regular Overtime	☐ Rate: $ ☐	→ Number of hours:	per ☐ Week	☐ Month	☐ Shift cycle
Other	☐ Explain:	→ Amount:	per ☐ Week	☐ Month	☐ Shift cycle

c. Do you have a second job? ☐ Yes ☐ No If yes – Employer's Name: Phone:
(Second employer may be contacted.)

d. Did you miss time from this second job? ☐ Yes ☐ No If yes, please attach earning information and time missed details.

Hours of Work

12 a. Number of hours (not including overtime): ☐ per ☐ Day ☐ Week ☐ Shift cycle ☐ Other

b. Does the work schedule repeat? ☐ No ☐ Yes → Mark hours worked for one complete work schedule (use zero for days off)

Average hours worked per week: ☐

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day							
Hours per day							
Hours per day							

IMPORTANT
Circle day of injury.
See instructions

or if your schedule is more than 21 days, attach a copy of the schedule.

c. Date shift cycle commenced (Year / Month / Day)

C 0 6 0 REV JAN 2011

Complete all three pages and sign the form before sending.

WORKER'S REPORT

Your Last Name:	First Name:	Initial:
Social Insurance #:	Date of Birth: *(Year / Month / Day)*	Phone:

Declaration and Consent

I declare that the information in the *Worker's Report of Injury or Occupational Disease* form will be true and correct.

I understand that:

- While I am receiving any benefits from WCB-Alberta, it is my obligation to inform WCB-Alberta immediately if I return to work of any kind, become capable of working or if there is any other change in my employment status. Work includes but is not limited to any activity in which labour or services are provided, whether or not payment of any kind is received.
- Criminal prosecution may result from any attempt on my part to collect benefits by providing false information, failing to provide information regarding my ability to work, or other fraudulent means.
- My employer may request a review or appeal of any decisions made on my claim and may therefore examine my claim file. My claim file may also be examined by anyone with a direct interest, as determined by WCB-Alberta, or a person or company I have authorized to review my claim file. (To provide authorization, use the *Worker's Information Release* form in this booklet).
- My social insurance number may be used for reporting to Canada Revenue Agency.
- WCB-Alberta may collect information that it considers relevant to determine benefit entitlement, including information pre-dating my accident, from any source including physicians, other health care providers, employer(s) and vocational rehabilitation service providers. This information is collected to determine my entitlement to compensation under the *Workers' Compensation Act*.

WCB-Alberta may use and disclose the information collected to determine entitlement, to provide services and benefits and, as required or authorized by law. This information may be used and disclosed pursuant to the *Workers' Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

(Year / Month / Day)

Date: _____ Name (please print): _____

Signature: _____

Signing the above consent enables the Workers' Compensation Board to process your claim.

NOTE: The information required in the *Worker's Report of Injury or Occupational Disease* is collected under sections 33(a) and (c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of determining entitlement to compensation and for determining employers' premium rates. Questions may be directed to the Claims Contact Centre as noted on the front of this form and on the back of the Worker Handbook. The information provided to the Workers' Compensation Board is protected by the provisions of the *Freedom of Information and Protection of Privacy Act*.

This report form is part of a booklet of information intended to help workers with completing the necessary WCB-Alberta forms and understanding the process. Keep the booklet for your reference.

C 0 6 0 REV JAN 2011

Injury Report Instructions

The numbers refer to question numbers on the form that may require additional explanation.

Worker Information

1 Have your work duties been modified?

Your duties have been modified if your employer made changes to regular job duties, as a result of an injury. For example, tasks or functions, workload (e.g., hours or work schedules), environment or work area, equipment.

Please indicate if you are working as an apprentice.

Employer Information

2 Please complete all the information.

Injury or Occupational Disease Information

3 Date and time of injury

If your injury developed over a period of time, indicate either the date of first medical treatment or the date you first reported it to your employer and check the box at the right. On the next line, give your start and end times on the day of the accident.

4 When was someone notified of your injury?

Please provide an accurate date and time someone from your work was made aware of your injury. Name the person, their position and their contact information.

If you could not report your injury immediately, please provide a reason.

5 Location of accident

Wherever the accident occurred, please provide a street address, if possible. Otherwise, indicate the location, such as 25 km east of Edmonton on Hwy 16, an oilrig site. If it is a motor vehicle accident, include the direction of travel. Check the appropriate box at the right to indicate whether the injury happened in Alberta.

6 Physical Demands

Sedentary
- Lifting 10 lbs maximum
- Occasional lifting and/or carrying
- Primarily sitting, with occasional walking/standing

Light
- Lifting 20 lbs maximum
- Frequent lifting and/or carrying up to 10 lbs
- May require significant walking/standing
- May involve sitting with pushing and pulling of arm and or leg controls

Medium
- Lifting 50 lbs maximum
- Frequent lifting/carrying up to 20 lbs
- May involve sitting with pushing and pulling of arm and/or leg controls

Heavy
- Lifting 100 lbs maximum
- Frequent lifting/carrying up to 50 lbs

Very Heavy
- Occasional lifting in excess of 100 lbs
- Frequent lifting/carrying excess of 50 lbs

Reference: The Canadian Classification and Dictionary of Occupations

7 Type of injury

Indicate the part of your body that was injured, what side of your body and what type of injury it is. When your doctor or chiropractor sends in your medical report we will confirm your injury.

8 Describe fully what happened to cause the injury

In your own words, tell us about your injury. If a repetitive strain injury, include your typical actions and how often you repeat them on the job – twisting, typing, pushing and pulling. If any lifting, indicate the weight.

Example: *I walked into our walk-in cooler to get a 50 lb. sack of potatoes. I bent down, picked up the sack, and turned to my right to leave. I felt a pull in my lower back and dropped the potatoes on my right foot. As a result, I injured my back and my right foot.*

Should you need more space than the area provided, please attach a letter.

Call the Claims Contact Centre 780-498-3999 or 1-866-922-9221 if you are reporting one of the following:

1. **Repetitive strain injury**
   For example, a typist developed tendonitis in the wrist as a result of job duties. Describe fully the job duties done each day. Include the time spent at each task.
2. **Occupational disease**
   Describe hearing loss, respiratory problems, etc. due to prolonged exposure to gas, chemicals, loud noises, etc.
3. **Motor vehicle accident**
   Send us a copy of the police report, when available. Fill out the Automobile Accident Report in this booklet.

Please fill in your name, Social Insurance Number and date of birth at the top of each page of the form in case the pages get separated.

Remember to complete all three pages and sign the form before sending.

Time Lost / Return-to-Work Information

9 Please complete all the information that applies.

Type of Employment

10 Complete one of the following A or B or C.

- Complete **A** if you work 12 months per year with the same employer.
- Complete **B** if you work only part of the year (subject to seasonal or lack of work layoffs).
- Complete **C** if you are self-employed, are a sub-contractor or do piecework.

Wage Information

11 b) Additional taxable benefits:

Vacation and statutory holiday pay
Please indicate if you are paid holiday and stat pay as an additional percentage on your paycheque (therefore must take these days off without pay) or, these days are included as days off with pay.

Shift premiums
Complete if you get paid in addition to your regular rate of pay (e.g., 50¢ paid per hour for night shift). If you get more than one shift premium (e.g., night premium, weekend premium), complete both shift premium boxes. Attach a list if you have three or more shift premiums.

Regular overtime
Complete only if you work the same number of hours overtime each week, month or shift cycle.

c) Second job

Provide a contact name and telephone number for a second job. If this injury causes you to miss earnings from that job, WCB-Alberta will consider these earnings when your compensation rate is set. Your second employer may be contacted.

If you do not know your hours of work and wage information, you can get them from your employer.

Hours of Work

12 a) Number of hours

Indicate your regular hours of work.
Do not include overtime here.

b) Does your work schedule repeat?

If no:

Report the average number of hours worked per week during the year prior to the injury. Do NOT complete the work schedule.

If yes:

Mark the number of hours you worked per day in each of the boxes. Put zero for days off. Please explain any codes you use in the boxes (for example: N=night, W=weekends, D=days, E=evenings). We need to know at what point in this work schedule you were injured to determine the compensation to pay you. Circle the day on this work schedule that you were injured. *See example below.*

Or:

If you have a work schedule **longer than 21 calendar days**, attach a copy of your schedule or describe your work schedule on a separate piece of paper. Circle the day on this work schedule that you were injured.

***Example:** You worked eight-hour days in the first week and eight-hour nights in the second and third weeks. You were injured on the Wednesday of the second week and were off work for two days (Thursday and Friday). You would be paid WCB-Alberta benefits for two days.*

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Hours per day:	8D	8D	8D	8D	O	O	O
Hours per day:	8N	8N	8N	8N	8N	8N	O
Hours per day:	8N	8N	8N	8N	8N	O	O

Important: Circle the day in the work schedule you were injured.

D = day • N = night • O = off