Workers' Compensation Board
Alberta

P.O. BOX 2415
EDMONTON AB
T5J 2S5
Fax: (780) 427-5863
1-800-661-1993

EMPLOYER'S REPORT
Of Injury or Occupational Disease

Claim Number:

Worker Information

☐ **Lost Time** ☐ **No Lost Time** ☐ **Modified Duties**

Last Name: First Name: Initial:

Address: Social Insurance #:

City: Province: Prov. Health Care #: - Prov.

Postal Code: Home Telephone: Date of Birth: Y M D Sex: ☐ M ☐ F

Occupation:

Employer Information

Employer Name or Government Dept.: Employer Account Number:

Industry:

Address: Does injured worker have personal coverage? ☐ Yes ☐ No

City: Is injured worker a partner or director in this business? ☐ Yes ☐ No

Province: Postal Code: Employer / Supervisor Contact Name:

Telephone: Fax: Telephone:

Injury or Occupational Disease Information

1 Date and time of injury: Y M D Time: ☐ am ☐ pm **OR** Did this condition develop over a period of time? ☐

Hours of employment on the day of accident: From To

2 When was injury reported to the employer? Y M D

3 Did injury occur on employer's premises? ☐ Yes ☐ No Location where accident happened (address or general location):

Did injury occur in Alberta? ☐ Yes ☐ No

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.

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

9 ☐ **NO LOST TIME** ☐ **MODIFIED DUTIES** ➔ **SIGN FIRST PAGE AND SEND TO THE WCB**

☐ **LOST TIME** ☐ **MODIFIED DUTIES** ➔ **COMPLETE SECOND PAGE**

Employer's Signature: Date:

If you have any other information that would help us make a decision, or you have concerns, please attach a letter.
☐ Please check this box if letter is attached.

(Registry Stamp)

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

Last Name: First Name: Initial:

Social Insurance #: Date of Birth: Y M D

Lost Time / Return to Work Information

10 a. Date and time worker first missed work: Y M D Hour: ☐ am ☐ pm

b. If worker has returned to work indicate date: Y M D and time: ☐ am ☐ pm ☐ regular work or ☐ modified work

c. Do you have modified duties worker can do until they are able to return to their regular job? ☐ Yes ☐ No

d. Will you continue the worker on pay during the period of disability? ☐ Yes ☐ No Net amount $

e. Date worker was hired? Y M D

Type of Employment

FILL IN **A** OR **B** OR **C**

11 **A** ☐ Permanent full time ☐ Permanent part time

B ☐ Seasonal work ☐ Summer student ☐ Irregular / casual ☐ Temporary

Had this injury not happened, what would have been your worker's last day of employment: ☐ Estimated or ☐ Actual Y M D

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

C ☐ Sub Contractor ☐ Piece work ☐ Vehicle Owner/Operator ☐ Welder Owner/Operator ☐ Apprentice

☐ Other or Self Employment - Explain:

Note: **Please also ask your employee to submit a detailed income and expense statement if you check any box in 11 C.**

Wage Information

12 a. Worker's rate of pay: $ ☐ hourly ☐ weekly ☐ bi-weekly ☐ monthly ☐ other:

b. Additional taxable benefits:

Vacation / Stat holiday Pay	☐	%:	→	☐ Taken as time off with pay	☐ Paid on regular basis		
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

Note: Only complete Question 13 if you are unable to complete Question 12. (Usually applies to seasonal or irregular/casual workers.)

13 a. Gross earnings for the period of one year or less: $ from: Y M D (12 months or less prior) to: Y M D (date before injury)

b. Was any time missed from work without pay during the above period? (eg. maternity, sick, work shutdown, WCB benefits, etc. - not vacation) ☐ Yes ☐ No

If yes, number of days: Reason:

Hours of Work

14 a. Number of hours: per ☐ day ☐ week ☐ shift cycle ☐ other:

b. Does work schedule repeat? ☐ Yes → Mark hours worked for one complete work schedule (use zero for days off):

☐ No → Report average hours worked per week:

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

IMPORTANT: Circle day of injury. See instructions

c. Date shift cycle commenced: Y M D

OR If your schedule is more than 21 days, attach a copy of schedule. ***Circle the day the injury occurred on this schedule.***

Earnings Information Contact (please print): Telephone Number: