Workers' Compensation Board
Alberta

P.O. BOX 2415
EDMONTON AB
T5J 2S5
Phone **780-498-3999** (in Edmonton)
1-866-WCB-WCB1 (922-9221) (toll free in Alberta)
Fax **(780) 427-5863** or **1-800-661-1993**

WORKER'S REPORT
of Injury or Occupational Disease

Claim Number

Worker Information

Will you be off work past the day of injury? ☐ Yes ☐ No **Modified duties?** ☐ Yes ☐ No

Last Name | First Name | Initial

Apt# | Address | Social Insurance #

City | Province | Prov. Health Care # | Prov.

Postal Code | Home Telephone | Date of Birth *(Year / Month / Day)* | Sex: ☐ M ☐ F

Occupation and Job Title at time of injury | Self employed? ☐ Yes ☐ No

If yes, account #

Employer Information

Employer Name or Government Dept.

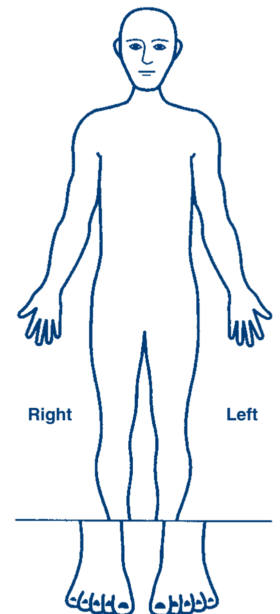
Address | Fax

City | Province | Postal Code | Telephone

Injury or Occupational Disease Information

1. Date and time of injury *(Year / Month / Day)* 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 did you report the injury to your employer? *(Year / Month / Day)* | Supervisor's Name
3. To whom did you report the injury? Name | Title | Telephone
   If not reported immediately, give the reason.
4. Did the injury occur on your employer's premises? ☐ Yes ☐ No Did the injury occur in Alberta? ☐ Yes ☐ No
   Location where accident happened (address or general location.)
5. 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. 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 any other information or a list of witnesses, attach a letter. Letter attached? ☐ **Yes**
Add separate page for more description.

9. Have you had a similar injury before? ☐ Yes ☐ No **If yes, attach a letter with details.**
10. Have you reported or claimed this injury to another WCB? ☐ Yes ☐ No If yes, which Province or Territory?

Name and address of treating Dr./Hospital

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

Complete all three pages and sign the form before sending.

C 0 6 0 REV JAN 2005

Your Last Name | First Name | Initial

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

Lost Time / Return to Work Information

11 **a.** Date and time you first missed work *(Year / Month / Day)* Hour ☐ am ☐ pm

b. If you have returned to work, indicate the date *(Year / Month / Day)* and time ☐ am ☐ pm ☐ regular work or ☐ modified work

c. If you have not returned to work give the expected return to work date *(Year / Month / Day)* **d.** Date you were hired *(Year / Month / Day)*

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

Who can we call? | Telephone

f. Will your employer pay you for the time you missed work? ☐ Yes ☐ No Provide the exact gross amount $ per

Type of Employment

FILL IN A OR B OR C Telephone

12 **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 last day of employment? ☐ Estimated or ☐ Actual *(Year / Month / Day)*

With this employer how many months per year would this job last?

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

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

☐ Other or Self Employment – Explain

Note: If you checked any box in 12C, please submit a detailed income and expense statement for the year prior to your date of accident.

Wage Information

13 **a.** Your 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

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

d. Did you miss time from this job? ☐ Yes ☐ No

If yes, please provide earning information and time missed details:

Hours of Work

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

b. Does the 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 *(Year / Month / Day)*

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

Complete all three pages and sign the form before sending.

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

Declaration and Consent

I declare that the information in my 'Worker's Report of Injury or Occupational Disease' to the Workers' Compensation Board (WCB) is true and correct. I understand that:

- If I am collecting any benefits, it is my obligation to inform the WCB 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 the WCB, 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 Customs and Revenue Agency.

I consent to WCB collecting any 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.*

Date (Year / Month / Day) ____________ 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 is collected under the authority of sections 32 and 36 of the *Workers' Compensation Act* for the purpose of determining entitlement to compensation and for determining employers' premium rates. Questions can be directed to the Customer 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 forms and understanding the process. Keep the booklet for your ongoing reference.