Alaska Department of Labor &
Workforce Development
Fishermen's Fund
PO Box 111149
Juneau, AK 99811-1149

Fishermen's Fund

FISHERMAN'S REPORT OF INJURY/ILLNESS & CLAIM FORM

Toll Free: 1-888-520-2766
Telephone: (907) 465-2766
Fax: (907) 465-5345
E-mail: fishfund@alaska.gov
www.labor.state.ak.us/wc/ffund.htm

You must seek treatment within 60 days of injury, and file a claim within one year of first treatment. Complete each item below - benefits cannot be paid if you do not provide the requested information. Attach a copy of your license/permit card with this form.

1. Name (Last, First, Middle Initial)		2. Sex ◯ M ◯ F	3. Date of Birth	4. Social Security No.
5. Street or PO Box Number		6. Home Telephone Number	7. Cell Phone Number	
8. City State Zip Code		9. E-mail Address optional		
10. Vessel Name	11. Owner of Vessel / Set Net Site	12. Vessel Owner's Telephone	13. Vessel Number	
14. Commercial Fishing License or Permit No.: _____ Date Purchased: Must Attach Copy		15. Date and Time of Injury or Onset of Illness Date: Time: ◯AM ◯PM		
16. Geographic Location at Time of Injury (Chart Name or Description, Nearest Landmark, etc.) Be Specific		17. Ill/Injured While ◯ Commercial Fishing ◯ Working on Gear/Boat ◯ Other:		
18. Resource Commercially Fished (ex. Salmon, Cod, Crab, etc.)		19. Gear Type (ex. Troll, Seine, Longline, Pot Gear, etc.)		

20. Is the vessel/site insured by a protection & indemnity (P&I) insurance policy? ◯ Yes ◯ No ◯Don't Know
If yes, Insurance Company Name: _____
Have you filed a claim against the vessel owner or the insurance company? ◯ Yes ◯ No

21. At the time of your injury/illness, did you have medical coverage (including private health insurance, Indian health services, veteran's affairs, Medicare, Medicaid, etc.)? ◯ Yes ◯ No
If yes, name of coverage provider:

22. What is the exact nature of your injury/illness? Be Specific _____

23. What caused the injury/illness? Be Specific _____

24. What were you doing at the time of injury? Be Specific _____

25. Was there a witness? ◯ Yes ◯ No If yes, witness name: _____
Witness Address: Telephone Number:

To all health care providers:
You are authorized to provide the Alaska Commercial Fishermen's Fund information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above in box 22. This information will be used to evaluate my entitlement to receive medical benefits from the Fund.

Claimant Signature: Date:

Warning: It is a crime to provide false information for the purpose of defrauding the Alaska Commercial Fishermen's Fund, or any other person. Penalties include fines and/or imprisonment. In addition, the Fund may deny all benefits if false information materially related to this claim was provided by the claimant.