



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			<input type="checkbox"/> Lost Time	<input type="checkbox"/> No Lost Time	<input type="checkbox"/> 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
Occupation:		Sex:	<input type="checkbox"/> M	<input type="checkbox"/> F	

Employer Information	
Employer Name or Government Dept.:	Employer Account Number:
	Industry:
Address:	Does injured worker have personal coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
City:	Is injured worker a partner or director in this business? <input type="checkbox"/> Yes <input type="checkbox"/> No
Province:	Postal Code:
Telephone:	Fax:
	Employer / Supervisor Contact Name:
	Telephone:

Injury or Occupational Disease Information	
1	Date and time of injury: Y M D Time: <input type="checkbox"/> am <input type="checkbox"/> pm OR Did this condition develop over a period of time? <input type="checkbox"/>
	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? <input type="checkbox"/> Yes <input type="checkbox"/> No Location where accident happened (address or general location):
	Did injury occur in Alberta? <input type="checkbox"/> Yes <input type="checkbox"/> 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.) <input type="checkbox"/> Left side <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
8	Were the actions part of the worker's regular duties? <input type="checkbox"/> Yes <input type="checkbox"/> No
9	<input type="checkbox"/> NO LOST TIME <input type="checkbox"/> MODIFIED DUTIES → SIGN FIRST PAGE AND SEND TO THE WCB
	<input type="checkbox"/> LOST TIME <input type="checkbox"/> MODIFIED DUTIES → COMPLETE SECOND PAGE

Employer's Signature: _____	Date: _____
If you have any other information that would help us make a decision, or if you have concerns, please attach a letter.	
<input type="checkbox"/> 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 Subcontractor Piecework 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 _____ to: Y M D _____
(12 months or less prior) (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
Hours per day:	_____	_____	_____	_____	_____	_____	_____
Hours per day:	_____	_____	_____	_____	_____	_____	_____
Hours per day:	_____	_____	_____	_____	_____	_____	_____

c. Date shift cycle commenced: Y M D _____

IMPORTANT: Circle day of injury. See instructions

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: _____