Workers' Compensation Board
Alberta

C394
WAGE LOSS

9912 - 107 STREET
PO BOX 2415
EDMONTON AB T5J 2S5
FAX: 780-427-5863

Claim Number:

Social Insurance #:

Worker's Name: *(Surname)* *(First Name)* *(Initial)*

Date of Accident *(Year / Month / Day)*

Address *Street* *City/Town* *Province* *(Postal Code)*

Telephone Number

The above named worker is required to attend an appointment (i.e. medical examination, DRDRB review meeting or appeal hearing) in relation to their claim. WCB can pay a wage loss allowance if the worker has a loss of earnings as a result of leaving work to attend the appointment.

TO ALLOW US TO PROPERLY REIMBURSE THE WORKER, PLEASE RETURN THE COMPLETED FORM TO THE ADDRESS OR FAX NUMBER NOTED ABOVE.

1. Will you pay the worker directly for the time missed to attend this appointment: ☐ Yes ☐ No
   If other, provide details: _____
2. Is the worker self employed? ☐ Yes ☐ No If yes, the worker must supply WCB with income and expenses for the period of one month prior to appointment date.
3. Time missed from work to attend appointment(s): _____ Hour or _____ Day or _____ Other (eg., trips)
4. Date(s) missed from work: _____
5. Rate of pay: $ _____ per ☐ Hour ☐ Day ☐ Month ☐ Yearly Gross ☐ Other
   Explain other _____
6. Number of hours worked per week/shift: _____
7. Circle the worker's usual day(s) **off** S M T W T F S or shift cycle if applicable: _____
8. Date shift cycle commenced: *(Year / Month / Day)*
9. Employer's Name: Telephone Number
   Address *Street* *City/Town* *Province* *(Postal Code)*

Contact Name (Print):

Contact Signature:

Official Title:

Date: *(Year / Month / Day)*