wcb Workers' Compensation Board – Alberta

P.O. BOX 2415
EDMONTON AB T5J 2S5

Phone **780-498-3999** (in Edmonton)
1-866-922-9221 (toll free in Alberta)
1-800-661-9608 (outside Alberta)

Fax **780-427-5863** or **1-800-661-1993**

November 2018

WORKER REPORT

of Injury or Occupational Disease **C060**

Seven digit claim #:

Worker Details

Past the date of injury: Have you been off work? ☐ Yes ☐ No

1 Have your work duties been modified? ☐ Yes ☐ No

Last name: First name: Initial:

Mailing address: Apt# _____ ,

Social Insurance #:

City: Province: Postal code:

Personal health #: –

Phone number:

Date of birth: (Year / Month / Day) Gender: ☐ M ☐ F

Occupation and job description:

Are you an apprentice? ☐ Yes ☐ No

If yes, date you would have obtained journeyman status: (Year / Month / Day)

Date hired: (Year / Month / Day)

Are you a partner or director in the business? ☐ Yes ☐ No

Do you have personal coverage? ☐ Yes ☐ No

If yes, coverage number:

Employer Details

2 Employer business name:

Mailing address:

City: Province: Postal code:

Contact name: Title: Phone: E-mail:

Accident Details

3 Date/time of accident: (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m. *or* ☐ the injury/condition developed over time

Date/time scheduled shift started (if applicable): (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

Date/time scheduled shift ended (if applicable): (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

4 Date accident/injury reported to employer: (Year / Month / Day)

Name of person and their position: Phone number:

If not reported immediately, give the reason:

5 Describe fully, based on the information you have, what happened to cause this injury or disease. Please describe what you were doing, including details about any tools, equipment, materials, etc. you were using. State any gas, chemicals or extreme temperatures you may have been exposed to:

☐ Cardiac condition/injury? ☐ Claimed to another WCB? Province: _____

☐ Motor vehicle accident? If you have a police collision report, please send a copy by mail or fax once you have a claim number. Please also complete the WCB Automobile Accident Report.

If you have more information or a list of witnesses, please attach a letter. Please check this box if letter is attached. ☐

Have you had a similar injury before? ☐ Yes ☐ No **If yes, attach a letter with details.**

Was the work you were doing for the purpose of your employer's business? ☐ Yes ☐ No Was it part of your usual work? ☐ Yes ☐ No

Did the accident/injury occur on employer's premises? ☐ Yes ☐ No

Location where the accident happened (address, general location or site):

6 Full name of treating hospital or healthcare professional:

Address:

Phone:

When did you first seek medical treatment? (Year / Month / Day) Is any further treatment required? ☐ Yes ☐ No

7 Did your employer provide health benefits to you at the time of the accident? ☐ Yes ☐ No

Will your employer continue paying the benefit premium? ☐ Yes ☐ No

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Complete all three pages and sign the form before sending.

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

Worker's last name:	Worker's first name:	Initial:
Social Insurance #:	Date of birth: (Year / Month / Day)	

Injury Details

What part of body was injured? (hand, eye, back, lungs, etc.) ☐ Left side ☐ Right side

What type of injury is this? (sprain, strain, bruise, etc.)

Return to Work Details

Please complete all that apply

☐ I understand that I have a legal obligation to cooperate with my employer and WCB in arranging my safe return to work. Exceptions: Short-term or some seasonal workers, subcontractors and workers with personal coverage.

8 a. Will/did your employer pay you while off work? ☐ Yes, pre-accident wages ☐ Yes, revised rate of pay ☐ No ☐ Unknown

Revised rate of pay: $_____ per _____

b. Date you first missed work: (Year / Month / Day) | c. If you have returned to work indicate date: (Year / Month / Day)

Current work status: ☐ Regular work duties, *or* ☐ Modified work duties ☐ Regular hours of work, *or* ☐ Modified hours of work: _____ hrs per _____

If you are working modified duties please describe:

Approximate date you expect to return to work: (Year / Month / Day)

Is your expected return to work: ☐ Within 2 weeks ☐ 2-8 weeks ☐ 2-6 months ☐ 6+ months ☐ Unknown

Employment Type Details

(Complete A or B or C. Select your type of employment.)

9 A Permanent position employed 12 months of the year:

☐ Permanent full-time ☐ Permanent part-time ☐ Irregular/casual

or **B** Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs):

☐ Seasonal worker ☐ Summer student ☐ Temporary position

Had this injury not occurred, your last day of employment would have been:

Position start: (Year / Month / Day) Position end: (Year / Month / Day) ☐ Estimated, *or* ☐ Actual

How many months or days are workers employed in this position? _____

or **C** Special employment circumstance:

☐ Sub contractor ☐ Vehicle owner/operator ☐ Welder owner/operator ☐ Commission ☐ Piece work ☐ Volunteer ☐ Self-employed

Do you incur expenses to perform the work (materials, tools, etc.)? ☐ Yes ☐ No Will you receive a T4? ☐ Yes ☐ No

Note: If you have checked any box in 8C please submit a detailed income and expense statement.

Earning Details

a. Your rate of pay at time of accident: $ _____ per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year

10 b. Additional taxable benefits:

Vacation pay: _____ ☐ Taken as time off with pay ☐ Paid on a regular basis % _____

☐ Shift premium
☐ Overtime
☐ Other

Please describe:

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

d. Did you miss time from this second job? ☐ Yes ☐ No If yes, please attach earning information and time missed details.

Complete all three pages and sign the form before sending.

Please fill in your name, Social Insurance Number and date of birth at the top of each page of the form in case the pages get separated.

Remember to complete all three pages and sign the form before sending.

Worker's last name:	Worker's first name:	Initial:
Social Insurance #:	Date of birth: (Year / Month / Day)	

Hours of Work Details

11 a. Number of hours (not including overtime): _____ per week

Describe your work schedule (e.g., Monday to Friday, on. Saturday to Sunday, off.):

_____

Declaration and Consent

I declare that the information in the Worker Report of Injury or Occupational Disease form will be true and correct.

I understand that:

- While I am receiving any benefits from WCB-Alberta, it is my obligation to inform WCB-Alberta 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 WCB-Alberta, or a person or company I have authorized to review my claim file. (To provide authorization, use the Worker's Information Release form in the *Worker Handbook*).
- My social insurance number may be used for reporting to Canada Revenue Agency.
- WCB-Alberta may collect 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*.

WCB-Alberta may use and disclose the information collected to determine entitlement, to provide services and benefits and, as required or authorized by law. This information may be used and disclosed pursuant to the *Workers' Compensation Act* and the *Freedom of Information and Protection of Privacy 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 Report of Injury or Occupational Disease* is collected under sections 33(a) and (c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of determining entitlement to compensation and for determining employers' premium rates. Questions may be directed to the Claims 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*.

If your injury was sustained in an automobile accident, fill out and send an Automobile Accident Report along with the Worker Report.