



Workers' Compensation Board
Alberta

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1-866-922-9221 (toll free in Alberta)
Fax: 780-427-5863 or 1-800-661-1993

January 2010

WORKER'S REPORT

of Injury or Occupational Disease C060

Seven Digit Claim #: _____

Worker Information

Past the day of injury: Have you been off work? Yes No Have your work duties been modified? Yes No

Last Name:		Former Name: (e.g., Maiden Name)		First Name:		Initial:	
Address:			Apt #:		Social Insurance #:		
City:		Province:		Postal Code:		Health Care #: _____ - _____ Province: _____	
Daytime Phone:		Evening Phone:		Date of Birth: _____ (Year / Month / Day)		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Occupation and Job Title at time of injury:				Self employed? <input type="checkbox"/> Yes <input type="checkbox"/> No → If yes, WCB-Alberta account #:			
E-mail address:				Apprentice? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Employer Information

Business Name or Government Department: _____

Mailing Address: _____ Fax: _____

City: _____ Province: _____ Postal Code: _____ Phone: _____

Injury or Occupational Disease Information

1 Date and time of injury: _____ (Year / Month / Day) Time: _____ a.m. p.m. or This condition developed over a period of time.

Scheduled hours of employment on the day of accident: From: _____ To: _____ (Year / Month / Day)

2 When was someone at your place of employment notified of your injury? _____ Time: _____ a.m. p.m.

Name of person and their position: _____ Phone: _____

If not reported immediately, give the reason: _____

3 Did the injury occur on your employer's premises? Yes No Did the injury occur in Alberta? Yes No

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

4 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

Please check the box that best describes the physical demands of your work: Sedentary Light Medium Heavy Very Heavy (see detailed description on page 22 of the Worker Handbook)

5 What part of your body was injured? Left side Right side

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

7 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 more information or a list of witnesses, please attach a letter. Please check this box if letter attached.

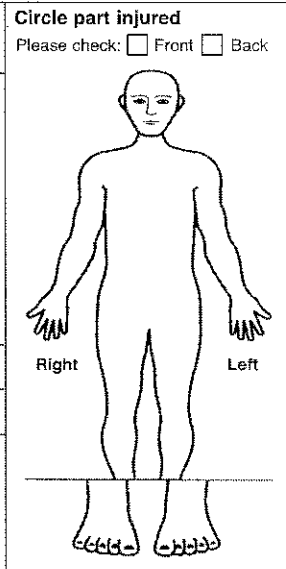
8 Have you had a similar injury before? Yes No If yes, attach a letter with details.

9 Have you reported or claimed this injury to another WCB? Yes No If yes, which Province or Territory? _____

10 Full name of treating hospital or healthcare professional: _____

Address: _____

Phone: _____ Date of first medical treatment: _____ (Year / Month / Day)



REV JAN 2010

Complete all three pages and sign the form before sending.
If your injury is the result of a motor vehicle accident, complete the Motor Vehicle Accident Report (L-054).

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

Time Lost / Return to Work Information PLEASE COMPLETE ALL THAT APPLY

11 a. Date and time you first missed work: _____ (Year / Month / Day) Time: _____ a.m. _____ p.m.
 b. Will/did your employer pay you while off work? No Yes, pre-accident wages Yes, but revised rate: \$ _____ per _____
 c. Is there any other work you can do until you are medically fit to return to your regular job? Yes No
 If yes, who can we call to discuss alternate work on your behalf? _____ Phone: _____
 d. If you have not returned to work give the expected return to work date: _____ (Year / Month / Day)
 e. If you have returned to work, indicate the date: _____ (Year / Month / Day) Time _____ a.m. _____ p.m. Regular work, or Modified work
 f. If back on modified work, are you: Being paid your pre-accident rate of pay? Yes No – provide rate: \$ _____ per _____
 Working pre-accident hours? Yes No – provide hours: _____ per _____

Type of Employment (Complete A or B or C)

12 **A** Permanent position employed 12 months of the year: Permanent full-time Permanent part-time
 or **B** Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs):
 Seasonal worker Temporary position Casual as needed Summer student Volunteer
 Had this injury not occurred, your last day of employment would have been: _____ (Year / Month / Day) Estimated or Actual
 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
 or **C** Special employment circumstance:
 Contractor/sub contractor Vehicle owner/operator Welder owner/operator Commission Piece work Other/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 12C please submit a detailed income and expense statement.

Wage Information Date you were hired: _____ (Year / Month / Day)

13 a. Your rate of pay at time of accident: \$ _____ Hourly Weekly Bi-weekly Semi-monthly Monthly Other
 b. Additional taxable benefits:
 Vacation Pay Included in rate of pay %: _____ OR Taken as time off with pay
 Stat Holiday Pay Included in rate of pay %: _____ OR Taken as time off with pay
 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: _____ Phone: _____
 (Second employer may be contacted.)
 d. Did you miss time from this second job? Yes No If yes, please attach earning information and time missed details.

Hours of Work

14 a. Number of hours (not including overtime): _____ per Day Week Shift cycle Other
 b. Does the work schedule repeat? No Yes → Mark hours worked for one complete work schedule (use zero for days off)
 Average hours worked per week: _____

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day							
Hours per day							
Hours 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.



Your Last Name:	First Name:	Initial:
Social Insurance #:	Date of Birth: <small>(Year / Month / Day)</small>	Phone:

Declaration and Consent

I declare that the information in the *Worker's 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 this booklet).
- 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*.

(Year / Month / Day)

Date: 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 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*.

This report form is part of a booklet of information intended to help workers with completing the necessary WCB-Alberta forms and understanding the process. Keep the booklet for your reference.

