Workers' Compensation Board
Alberta

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EDMONTON AB
T5J 2S5
Phone: **780-498-3999** (in Edmonton)
1-866-922-9221 (toll free in Alberta)
Fax: **780-427-5863** or **1-800-661-1993**

March 2008

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: ☐ M ☐ F

Occupation and Job Title at time of injury: | Self employed? ☐ Yes ☐ No → If yes, WCB account #:

E-mail address: | Apprentice? ☐ Yes ☐ 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:

2 When was someone at your place of employment notified of your injury? (Year / Month / Day) 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 20 of the Worker Handbook)

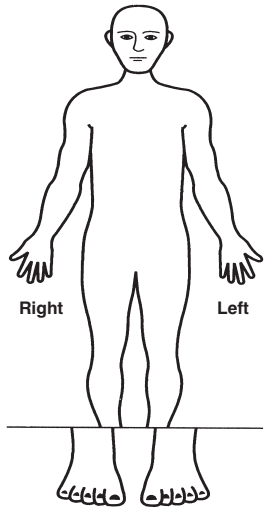
5 What part of your body was injured? (hand, eye, back, lungs, etc.) ☐ Left side ☐ Right side

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. ☐

Circle part injured
Please check: ☐ Front ☐ Back



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)

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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 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

or if your schedule is more than 21 days, attach a copy of the schedule.

c. Date shift cycle commenced
(Year / Month / Day)

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Complete all three pages and sign the form before sending.

Your Last Name:	First Name:	Initial:
Social Insurance #:	Date of Birth: *(Year / Month / Day)*	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, it is my obligation to inform WCB 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, 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 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 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 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 forms and understanding the process. Keep the booklet for your reference.