Workers' Compensation Board
Alberta

P.O. BOX 2415
EDMONTON AB
T5J 2S5

Claims Information
Phone: **(780) 498-3800**
Fax: **(780) 427-5863 or 1-800-661-1993**

WORKER'S REPORT
Of Injury or Occupational Disease

Claim Number:

Worker Information

Will you be off work past the day of injury? ☐ Yes ☐ No

Last Name: First Name: Initial:

Address: | Social Insurance #:

City: Province: | Prov. Health Care #: - Prov.

Postal Code: Home Telephone: | Date of Birth: *(Year / Month / Day)* Sex: ☐ M ☐ F

Occupation and Job Title at time of injury: | Self employed? ☐ Yes ☐ No

If yes, account #:

Employer Information

Employer Name or Government Dept. Supervisor's Name:

Address: Fax:

City Province: Postal Code: Telephone:

Injury or Occupational Disease Information

1 Date and time of injury: *(Year / Month / Day)* Time: ☐ am ☐ pm **OR** Did this condition develop over a period of time? ☐

Hours of employment on the day of accident: From To

2 When did you report injury to your employer? *(Year / Month / Day)*

3 To whom did you report the injury? Name: Title: Telephone:

If not reported immediately, give reason:

4 Did injury occur on your employer's premises? ☐ Yes ☐ No Location where accident happened (address or general location):

Did injury occur in Alberta? ☐ Yes ☐ No

5 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

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

Circle part injured:
Please check: ☐ Front ☐ Back

Right Left

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

8 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 any other information or a list of witnesses, attach a letter. Letter attached? ☐ **Yes**

If your injury is the result of a motor vehicle accident complete the Motor Vehicle Accident Report (L-054)

Complete all three pages and sign the form before sending

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Your Last Name: First Name: Initial:

Social Insurance #: Date of Birth: (Year / Month / Day)

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

10 Have you reported or claimed this injury to another WCB? ☐ Yes ☐ No If yes, Province:

Name and address of treating Doctor/Hospital:

Lost Time / Return to Work Information

11 a. Date and time you first missed work: (Year / Month / Day) Hour: ☐ am ☐ pm

b. If you have returned to work indicate date: (Year / Month / Day) and time: ☐ am ☐ pm ☐ regular work or ☐ modified work

c. If you have not returned to work give expected return to work date: (Year / Month / Day) d. Date you were hired: (Year / Month / Day)

d. Is there any other work you can do until you are medically fit to return to your regular job? ☐ Yes ☐ No

Who can we call? Telephone:

e. Will your employer pay you for the time you missed work? ☐ Yes ☐ No Provide the exact gross amount: $ per

Type of Employment

FILL IN **A** OR **B** OR **C**

12 **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 last day of employment: ☐ Estimated or ☐ Actual (Year / Month / Day)

With this employer how many months per year would this job last?

Did you have any other earnings or income from any other employers during this last 12 months? ☐ Yes -Please attach copies of pay stubs and/or T4 slips

C ☐ Sub Contractor ☐ Piece work ☐ Vehicle Owner/Operator ☐ Welder Owner/Operator ☐ Apprentice

☐ Other or Self Employment - Explain:

Note: **Please submit a detailed income and expense statement if you check any box in 12 C.**

Wage Information

13 a. Your 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

c. Do you have a second job? ☐ Yes ☐ No If yes - Employer's Name: Telephone :

Second employer may be contacted

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):

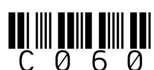
☐ No ➔ Report average hours worked per week:

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hrs per day							
Hrs per day							
Hrs 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 schedule. *Circle the day the injury occurred on this schedule.*



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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 ongoing reference.

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

This page may be provided separate from the balance of the Worker's Report of Injury or Occupational Disease, as required by the WCB.

Declaration and Consent

I declare that the information in my 'Worker's Report of Injury or Occupational Disease' to the Workers' Compensation Board (WCB) is true and correct. I understand that:

- If I am collecting any benefits, it is my obligation to inform the 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.
- 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 the WCB, or a person or company I have authorized to review my claim file. (To provide authorization, use the 'Workers' Information Release Form' in this booklet).
- My social insurance number may be used for reporting to Revenue Canada.

I consent to WCB collecting any 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.

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's Report of Accident is collected under the authority of Section 27 and 31 of the Workers' Compensation Act for the purpose of determining entitlement to compensation and for determining employer's premium rates. Questions can be directed to Claims Information as noted on the front of this report and on the back of the Worker Handbook. The information provided to the Worker's Compensation Board is protected by the provisions of the *Freedom of Information and Protection of Privacy Act.*