WCB-Alberta

Employer Report of Injury or Occupational Disease

Reporting an injury

By law, employers are required to report injuries that their workers suffer while on the job. If your worker has been injured, you have **72 hours** after becoming aware of an injury or illness to submit the Employer Report of Injury form. The sooner we receive your information, the faster we can determine entitlement to benefits and services for your worker.

You need to submit a report to WCB if the accident results in, or is likely to result in:

- **lost time or the need to temporarily or permanently modify work** beyond the date of accident.
- **death or permanent disability** (amputation, hearing loss, etc.).
- **a disabling or potentially disabling condition** caused by occupational exposure or activity (such as a mental health concern, poisoning, infection, respiratory disease, dermatitis, etc.).
- **the need for medical or mental health treatment beyond first aid** (assessment by physician, psychologist, physiotherapist, chiropractor, etc.).
- **incurring medical aid expenses** (dental treatment, eyeglass repair or replacement, prescription medications, etc.).

Option 1:
Report online using myWCB

myWCB provides you with access to a number of online services, including reporting. Through myWCB, electronic injury reporting will guide you through the reporting process and provide you with help along the way.

To learn more about myWCB, visit our website under *Resources > For employers > Online services*.

Option 2:
Report in the myWCB employer mobile app

The myWCB employer mobile app provides you a quick and convenient way to report an injury. It is available in the *App Store* and *Google Play*.

To learn more about the app, visit our website under *Resources > For employers > Online services*.

Option 3:
Report by fax

If you are unable to access our online services you can submit the injury form by fax to:

780-427-5863 (Edmonton)
1-800-661-1993 (within Canada)

If you fax the report, do not send another copy by mail.

Option 4:
Submit a one-time injury report

If you are unable to sign up for online services you can still submit a one-time injury report online.

Visit our website under *Claims > Report an injury > For employers*.

If you have questions or need help reporting, call us.

Inside Alberta: 1-866-922-9221 Outside Alberta: 1-800-661-9608 (in Canada)

wcb Workers' Compensation Board – Alberta

Employer Report Instructions

The numbers refer to question numbers on the form that may require additional explanation.

If you are unclear or need assistance completing this form, call 1-866-922-9221.

Claim Type

1 Time Lost (TL)
Check this box if your worker is off work past the day of the injury. (Complete the entire form.)

Modified Work
Check this box if your worker's duties have changed because of the injury. Modified work includes a change in duties, job, hours, or amount of work. If your worker is on modified work beyond the day of the accident, the injury must be reported to WCB even if there is no time lost or loss of earnings. (Complete both pages of the form.)

No Time Lost (NTL)
Check this box if your worker will not miss work beyond the day of the injury. (Complete all sections except for section 8, 9, 10 and 11.)

Worker Details

Please provide as much information as possible.

Employer Details

2 Employer/supervisor contact
Provide the contact name and number of the person in your company managing your worker's claim and return to work.

Accident Details

3 Date & time of accident
If the injury/condition or occupational disease developed over a period of time, indicate the date you first became aware of the injury.

4 Date accident/injury reported to employer
Name the date, time, person, position and contact information.

5 Describe what happened to cause the injury
Include typical actions and how often they are repeated on the job (e.g., twisting, typing, pushing, and pulling). If there is any lifting, indicate the weight.

If you need more space than the area provided, please attach a letter.

Example:
Bob walked into our walk-in cooler to get a 50 lb. sack of potatoes. He bent down and picked up the sack, turned to his right to leave. He felt a pull in his lower back and dropped the potatoes on his right foot, also injuring his right foot.

6 Location of accident
This information may be needed to determine:

- whether your worker was performing duties in the course of employment, OR
- whether the injury occurred due to the negligence of another party.

Provide a street address, if possible, indicate the location (e.g., 25 km east of Edmonton on Highway 16, an oil rig site). If it is a motor vehicle accident, include the direction of travel.

Call the claims contact centre 780-498-3999 or 1-866-922-9221 if you are reporting one of the following:

1. Repetitive strain injury
For example, a typist developed tendonitis in the wrist as a result of job duties. Describe fully what job duties are done each day. Include the time spent at each task.

2. Occupational disease
Describe hearing loss, respiratory problems, etc. due to prolonged exposure to gas, chemicals, loud noises, etc.

3. Motor vehicle accident
Send us a copy of the police report, when available.

Report faster in the myWCB employer mobile app.
By signing in with your myWCB login, the app pre-populates some of these details for you. It further streamlines reporting by guiding you through the report with questions to determine what information is required based on the circumstances of the claim.

University of Calgary - Student

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**

OCTOBER 2021

EMPLOYER REPORT
of Injury or Occupational Disease

C040

Seven digit claim # (if available):

Claim Type

1 ☐ **Time lost** ☐ **Modified work** ☐ **Fatality**
Complete entire report if claim type is one of the above

☐ **No time lost (Notice of non-disabling injury/illness)**
Complete all sections except for section 8, 9, 10 and 11

Worker Details

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 ☐ X

Email address:

Occupation: Job description: Date hired: (Year / Month / Day)

Does the worker have WCB personal coverage with this business? ☐ Yes ☐ No Is the worker a partner or director in this business? ☐ Yes ☐ No

Is the worker an apprentice? ☐ Yes ☐ No If yes, date the worker would have obtained journeyman status: (Year / Month / Day)

Employer Details

Business name or government department:
Alberta Advanced Education

Mailing address: 2300 Commerce Place, 10155 102 St NW

City: Edmonton

Province: Alberta Postal code: T5J 4G8

Phone: 403-220-5719 Fax:

WCB account number: 9773827 Industry: 9 3 2 0 0

2 Employer/Supervisor contact name and title:

Contact phone:

Contact e-mail:

Accident Details

3 Date and time of accident: (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

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

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

or ☐ the injury/condition developed over time

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

To whom was the accident/injury reported?: Phone number:

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

Motor vehicle accident? ☐ Yes ☐ No If you have a police collision report, please mail or fax it to us once you have a claim number available. Please include the worker's name and claim number.

If you have more information, please attach a letter.
Letter attached? ☐ Yes ☐ No

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

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

Were the worker's actions at the time of injury for the purpose of your business? ☐ Yes ☐ No

Were the actions part of the worker's regular duties? ☐ Yes ☐ No

Page two of form

Please fill in your worker's name, Social Insurance Number, and date of birth at the top of the second page in case the pages get separated.

Accident Details *(continued)*

7 Do you have any concerns affecting the acceptance of this claim?
Use this area to describe your concerns. If you need more space, please attach a letter.

Return to Work Details

8 Please fill out all of the information that applies.

Employment Type Details

9 Complete one of the following A or B or C

- Complete A if your worker works for you 12 months per year.
- Complete B if your worker works only part of the year, even though you may call the worker back to work each year. To correctly set the amount of compensation, we need to know the total number of days or months per year you would employ someone doing the same job as the injured worker, even if the work period starts and ends several times.
- Complete C if the injured person is an owner/operator, subcontractor, or does piece work.

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

Accident Details *(continued)*

7 Do you have any concerns affecting the acceptance of this claim? If you need more space, please attach a letter. ☐ Yes ☐ No

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.)

8 Return to Work Details

☐ I understand I have a duty to cooperate with WCB in coordinating a safe and healthy return to work for my injured worker.

a. Will/Did you pay the worker regular pay while off work? ☐ Yes ☐ No Has the worker returned to work? ☐ Yes ☐ No

b. Date worker first missed work: (Year / Month / Day)

c. If the worker has 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 _____

☐ Pre-accident rate of pay, *or* ☐ Revised rate of pay: $_____ per _____ ☐ Not working

d. Has modified work been offered? ☐ Yes ☐ No

Please describe the modified duties offered or currently performing:

Do you need assistance identifying modified work opportunities? ☐ Yes ☐ No

e. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? ☐ Yes ☐ No ☐ Was offered but the worker declined

f. Approximate return to work date: (Year / Month / Day)

9 Employment Type Details (Complete A or B or C. Select the worker's type of employment.)

A ☐ Permanent position employed 12 months of the year: ☐ Full time ☐ 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 start date: (Year / Month / Day) Position end date: (Year / Month / Day) ☐ Estimated ☐ Actual

How many months or days per year do you employ workers in this position?

or **C** Alternate employment: ☐ Sub contractor ☐ Piece work ☐ Vehicle owner/operator ☐ Welder owner/operator

☐ Self-employed ☐ Volunteer ☐ Commission ☐ Other

Does the worker incur expenses to perform the work (substantial materials, heavy equipment, larger tools, etc.)? ☐ Yes ☐ No

Will the worker receive a T4? ☐ Yes ☐ No

Please fill in your worker's 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)	

10 Earnings Details Choose A or B:

Earnings information contact name (please print):

Earnings contact phone number: Earnings contact e-mail:

A Gross earnings for the period of one year prior to the date of injury or date the worker was hired if less than one year: $ from: (Year / Month / Day) to (Year / Month / Day)

Was any time missed from work **without pay** during the above period, excluding vacation? (eg. maternity, sick, WCB benefits) ☐ Yes ☐ No

Dates and reasons:

or **B** Worker's hourly rate of pay at time of accident: $

Additional taxable benefits:

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

Shift premium gross earnings: $ from: (Year / Month / Day) to (Year / Month / Day)

Overtime gross earnings: $ from: (Year / Month / Day) to (Year / Month / Day)

Other gross earnings: $ from: (Year / Month / Day) to (Year / Month / Day)

11 Hours of Work Details

a. Number of hours (not including overtime): per ☐ Day ☐ Week ☐ Shift cycle ☐ Other: _____

b. Does the work schedule repeat?

☐ No → Average regular hours worked per week (not including overtime):

☐ Yes →

Date shift cycle commenced: (Year / Month / Day)

Mark hours worked for one complete work schedule (use zero for days off):

	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.*

Employer's signature: _____ Date: (Year / Month / Day)

If you have any other information that would help us make a decision, or if you have concerns, please attach a letter.

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH A DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW OR APPEAL.

Earnings Details

10 Complete one of the following A or B

A. Gross earnings
Provide the worker's gross earnings for the 1 year period prior to the date of injury; or from the date the worker received a pay raise or job change in the past year; or from the date the worker was hired if less than 1 year from the date of injury.

Example:
Your worker was injured on June 4, 2014. Provide gross earnings for the period June 4, 2013 to June 3, 2014. A T4 slip for the previous year is not sufficient.

Gross earnings include:
- Basic hourly, weekly, biweekly, or monthly pay
- Overtime pay
- Shift differentials
- Bonuses
- Statutory Holiday pay
- Gratuities
- The dollar value of the employer-subsidized portion of employer-provided accommodation if the worker loses the accommodation because of the accident.
- The dollar value of an isolation allowance if the allowance is a permanent part of the job and the worker loses the allowance because of the compensable accident.
- The dollar value of travel, subsistence and lodging allowances if they are recorded as taxable benefits.

Gross earnings not to include:
- Non-taxable income
- Severance Pay
- Pay in Lieu of Notice
- Reimbursement of Expenses
- Employer paid RRSP/RPP contributions
- Employer paid AHC premiums
- Employer paid group insurance premiums
- Dividend income

Time missed from work without pay
These are periods your worker missed because of maternity leave, or sick leave **without pay**. Do not include vacation, shutdown or lack of work periods.

B. Hourly Rate

Additional taxable benefits:

Vacation and statutory holiday pay
Please indicate if your worker is paid holiday and stat pay as an additional percentage on their paycheque or if these days are taken as time off with pay.

Shift premiums
Complete if your worker receives pay in addition to the regular rate of pay (e.g., 50¢ paid per hour for night shift). Provide the worker's gross shift premium earnings for the one year prior to the date of injury (less if they have not worked a full year).

Overtime
Complete only if your worker works overtime throughout the year.

Other
Use this if your worker gets any other taxable earnings (e.g., permanent accommodation, company car, northern living allowance, bonus).

Hours of Work Details

11 a. Number of Hours
Indicate the regular hours of work, not including overtime periods.

b. Does work schedule repeat?

If No:
Report the average number of regular hours worked per week during the year prior to the injury. Do NOT complete the work schedule.

If Yes:
Mark the number of regular hours worked per day in each of the boxes. Put zero for days off. Explain any codes you use in the boxes (for example, N=night, W=weekends, D=days, E=evenings). We need to know at what point in this work schedule your worker was injured to determine the compensation to pay. Circle the day in the work schedule your worker was injured.

See example below.

OR: If the work schedule is longer than **21 calendar days**, attach a copy of the schedule. Circle the day on this work schedule that your worker was injured.

Example: *Your worker worked 8-hour days in the first week and 8-hour nights in the second and third weeks. Your worker was injured on the Wednesday of the second week and was off work for 2 days (Thursday and Friday). Your worker would be paid WCB benefits for 2 days.*

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day:	8D	8D	8D	8D	0	0	0
Hours per day:	8N	8N	8N	8N	8N	8N	0
Hours per day:	8N	8N	8N	8N	8N	0	0

Important: *Circle the day in the work schedule your worker was injured.*

What happens when your worker is injured at work?

1 Employer

Your worker immediately informs you. You complete and send a form to WCB within 72 hours.

2 Doctor

Your worker sees a doctor about the injury. The doctor completes and sends a form to WCB within 48 hours of your worker's visit.

3 Worker

Your worker completes a *Worker Report of Injury or Occupational Disease* form and sends it to WCB as soon as possible.

Employer's Report

Doctor's Report

Worker's Report

WCB registers your worker's claim and assigns it to a staff member.

If more information is required to make a decision or if some is missing, WCB will contact you, your worker, or their doctor. ***This causes delays in payment.***

Claim not accepted

The legislative and policy requirements were not met by the information collected. Your worker will be advised of the reason by phone and in writing. They have the option to appeal within one year.

Appeal

Claim accepted

The legislative and policy requirements were met. Benefits and services may include

- Wage loss replacement
- Medical costs
- Case management services
- Return-to-work assistance

Time lost claims

WCB assigns your worker's claim to an **adjudicator** who makes the initial benefit decisions.

If your worker needs additional rehabilitation support to return to work, the claim may be transferred from an adjudicator to a **case manager.**

No time lost claims

Your worker has not missed work past the day of injury, a **claim process team** will monitor their medical treatment.

Teams also review letters and reports for evidence a claim may require adjudication.

Any questions?

Edmonton: 780-498-3999
Calgary: 403-517-6000
Toll Free: 1-866-922-9221

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