Injury Report Instructions

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

Worker Information

1. Have your work duties been modified?
   Your duties have been modified if your employer made changes to regular job duties, as a result of an injury. For example, tasks or functions, workload (e.g., hours or work schedules), environment or work area, equipment.
   Please indicate if you are working as an apprentice.

Employer Information

2. Please complete all the information.

Injury or Occupational Disease Information

3. Date and time of injury
   If your injury developed over a period of time, indicate either the date of first medical treatment or the date you first reported it to your employer and check the box at the right. On the next line, give your start and end times on the day of the accident.

4. When was someone notified of your injury?
   Please provide an accurate date and time someone from your work was made aware of your injury. Name the person, their position and their contact information.
   If you could not report your injury immediately, please provide a reason.

5. Location of accident
   Wherever the accident occurred, please provide a street address, if possible. Otherwise, indicate the location, such as 25 km east of Edmonton on Hwy 16, an oilrig site. If it is a motor vehicle accident, include the direction of travel. Check the appropriate box at the right to indicate whether the injury happened in Alberta.

6. Physical Demands
   Sedentary
   - Lifting 10 lbs maximum
   - Occasional lifting and/or carrying
   - Primarily sitting, with occasional walking/standing
   Light
   - Lifting 20 lbs maximum
   - Frequent lifting and/or carrying up to 10 lbs
   - May require significant walking/standing
   - May involve sitting with pushing and pulling of arm and/or leg controls
   Medium
   - Lifting 50 lbs maximum
   - Frequent lifting/carrying up to 20 lbs
   - May involve sitting with pushing and pulling of arm and/or leg controls
   Heavy
   - Lifting 100 lbs maximum
   - Frequent lifting/carrying up to 50 lbs
   Very Heavy
   - Occasional lifting in excess of 100 lbs
   - Frequent lifting/carrying excess of 50 lbs

   Reference: The Canadian Classification and Dictionary of Occupations

7. Type of injury
   Indicate the part of your body that was injured, what side of your body and what type of injury it is. When your doctor or chiropractor sends in your medical report we will confirm your injury.

8. Describe fully what happened to cause the injury
   In your own words, tell us about your injury. If a repetitive strain injury, include your typical actions and how often you repeat them on the job – twisting, typing, pushing and pulling. If any lifting, indicate the weight.
   Example: I walked into our walk-in cooler to get a 50 lb. sack of potatoes. I bent down, picked up the sack, and turned to my right to leave. I felt a pull in my lower back and dropped the potatoes on my right foot. As a result, I injured my back and my right foot.
   Should you need more space than the area provided, please attach a letter.

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 the job duties 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. Fill out the Automobile Accident Report in this booklet.
WORKER'S REPORT of Injury or Occupational Disease

Seven Digit Claim #: C060

University of Calgary - STUDENT

Worker Information

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

Have your work duties been modified? ☐ Yes ☐ No

Last Name: ☐

First Name: ☐

Initial: ☐

Address: ☐

Apt #: ☐

Social Insurance #: ☐

Health Care #: ☐

Province: ☐

Date of Birth: (Year / Month / Day)

Sex: ☐ M ☐ F

City: ☐

Province: ☐

Postal Code: ☐

Daytime Phone: ☐

Evening Phone: ☐

Date and time of injury: ☐

This condition developed over a period of time.

or

Scheduled hours of employment on the day of accident: From: ☐

To: ☐

When was someone at your place of employment notified of your injury? (Year / Month / Day)

Phone: ☐

If not reported immediately, give the reason:

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):

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)

What part of your body was injured?

☐ Left side ☐ Right side

What type of injury is this?

☐ sprain, strain, bruise, etc.

☐ (hand, eye, back, lungs, etc.)

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.

Have you had a similar injury before? ☐ Yes ☐ No

If yes, attach a letter with details.

Have you reported or claimed this injury to another WCB? ☐ Yes ☐ No

If yes, which province or territory?

Full name of treating hospital or healthcare professional:

Address:

Phone:

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

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).
Time Lost / Return-to-Work Information

Please complete all the information that applies.

Type of Employment

Complete one of the following A or B or C.
• Complete A if you work 12 months per year with the same employer.
• Complete B if you work only part of the year (subject to seasonal or lack of work layoffs).
• Complete C if you are self-employed, are a subcontractor or do piecework.

Wage Information

b) Additional taxable benefits:

Vacation and statutory holiday pay
Please indicate if you are paid holiday and stat pay as an additional percentage on your paycheque (therefore must take these days off without pay) or, these days are included as days off with pay.

Shift premiums
Complete if you get paid in addition to your regular rate of pay (e.g., 50¢ paid per hour for night shift). If you get more than one shift premium (e.g., night premium, weekend premium), complete both shift premium boxes. Attach a list if you have three or more shift premiums.

Regular overtime
Complete only if you work the same number of hours overtime each week, month or shift cycle.

c) Second job

Provide a contact name and telephone number for a second job. If this injury causes you to miss earnings from that job, WCB-Alberta will consider these earnings when your compensation rate is set. Your second employer may be contacted.

If you do not know your hours of work and wage information, you can get them from your employer.

Hours of Work

a) Number of hours

Indicate your regular hours of work. Do not include overtime here.

b) Does your work schedule repeat?

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

If yes:
Mark the number of hours you worked per day in each of the boxes. Put zero for days off. Please 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 you were injured to determine the compensation to pay you. Circle the day on this work schedule that you were injured. See example below.

Or:
If you have a work schedule longer than 21 calendar days, attach a copy of your schedule or describe your work schedule on a separate piece of paper. Circle the day on this work schedule that you were injured.

*Example: You worked eight-hour days in the first week and eight-hour nights in the second and third weeks. You were injured on the Wednesday of the second week and were off work for two days (Thursday and Friday). You would be paid WCB-Alberta benefits for two days.

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Important: Circle the day in the work schedule you were injured.

D = day  •  N = night  •  O = off
### Time Lost / Return to Work Information

**PLEASE COMPLETE ALL THAT APPLY**

9. 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:

9. 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)

10. A Permanent position employed 12 months of the year: [ ] Permanent full-time [ ] Permanent part-time

   or  

10. 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 [ ] 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  

10. 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)


   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

12. 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

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

      Hours per day

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

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.