Injury Report Instructions

kers' Compensation Board – Alberta

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

Worker Details

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 Details

2 Please complete all the information.

Accident Details

3 Date and time of accident

If your injury developed over a period of time, indicate either the date of first medical treatment or the date

P.O. BOX 2415
EDMONTON AB T5J 2S5

(in Edmonton)
(toll free in Alberta)
(outside Alberta)

or

APRIL 2021

WORKER REPORT

of Injury or Occupational Disease **C060**

Seven digit claim #:

Worker Details

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

1 ☐ Yes ☐ No

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 and job description:

Are you an apprentice? ☐ Yes ☐ No

If yes, date you would have obtained journeyman status: (Year / Month / Day)

Date hired: (Year / Month / Day)

Are you a partner or director in the business? ☐ Yes ☐ No

Do you have personal coverage? ☐ Yes ☐ No

If yes, coverage number:

Employer Details

Employer business name:

Mailing address:

City: Province: Postal code:

Contact name: Title: Phone: E-mail:

Complete all three pages and sign the form before sending.

Please fill in your 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.

Injury Details

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.

❼ Return-to-Work Details

Please complete all the information that applies.

Employment Type Details

❽ 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 sub-contractor or do piecework.

Earnings Details

❾b) 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 or, if these days are included as days off with pay.

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

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

❾ 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 Details

❿ a) Number of hours

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

For information about WCB-Alberta benefits and services, please have a look at our Worker Handbook. It explains what you can expect during your claim and may answer some of the questions you have.

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REV APR 2021

Complete all three pages and sign the form before sending.

If your injury was sustained in an automobile accident, fill out and send an Automobile Accident Report along with the Worker Report.