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**

APRIL 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:

WCB account number: Industry:

2 Employer/Supervisor contact name and title:

Mailing address:

City:

Province: Postal code:

Contact phone:

Phone: Fax:

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

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

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.)

7 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)

8 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

9 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)

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 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.