Workers' Compensation Board – Alberta

Box 2415
Edmonton AB T5J 2S5
Fax: (780) 427-5863
1-800-661-1993

C394
WAGE LOSS

Claim number:

Social insurance #:

Worker's name: *(Surname)* *(First name)* *(Initial)*

Date of accident: *(YYYY / MM / DD)*

Address: *Street* *City/Town* *Province*

Postal code:

Telephone number:

The above named worker is required to attend an appointment (i.e. medical examination or appeal hearing) in relation to their claim. WCB can pay a wage loss allowance if the worker has a loss of earnings as a result of leaving work to attend the appointment.

TO ALLOW US TO PROPERLY REIMBURSE THE WORKER, PLEASE RETURN THE COMPLETED FORM TO THE ADDRESS OR FAX NUMBER NOTED ABOVE.

1. Will you pay the worker directly for the time missed to attend this appointment? ☐ Yes ☐ No

Please note, WCB does not reimburse employers for time missed due to appointments.
Therefore, if you would like WCB to pay the worker for this time missed, please do not pay them directly.

2. Is the worker self employed? ☐ Yes ☐ No

If yes the worker must supply WCB with either a copy of their previous years T1 General Option C from Revenue Canada or supply WCB with income and expense for the period of one month prior to the appointment date.

3. Total time missed from work to attend appointment(s):

_____ Total hours

4. Date(s) missed from work:

5. Rate of pay: $ _____ per

☐ Hour ☐ Month ☐ Yearly gross ☐ Other

For any other rate of pay, please provide a detailed explanation and the worker's gross earnings for the month prior to the date(s) missed from work:
Other rate of pay:

Gross earnings from YYYY/MM/DD to YYYY/MM/DD = $ _____

6. Average number of hours worked per week:

7. Employer's name:

Telephone number:

Address: *Street* *City/Town* *Province:* *Postal code:*

Email address:

Contact name (print):

Contact signature:

Official title:

Date: *(Year / Month / Day)*