

Seven digit claim #: _____

Worker Details		Past the date of injury: Have you been off work? <input type="checkbox"/> Yes <input type="checkbox"/> No	1 Have your work duties been modified? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X
Email address:			
Occupation and job description:			
Are you an apprentice? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have personal coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, coverage number:	

Employer Details		2 Employer business name:	
Mailing address:			
City:	Province:	Postal code:	
Contact name:	Title:	Phone:	E-mail:

Accident Details	
3 Date/time of accident: _____ (Year / Month / Day)	Time: _____:_____:_____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. or <input type="checkbox"/> the injury/condition developed over time
Date/time scheduled shift started (if applicable): _____ (Year / Month / Day)	Time: _____:_____:_____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Date/time scheduled shift ended (if applicable): _____ (Year / Month / Day)	Time: _____:_____:_____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
4 Date accident/injury reported to employer: _____ (Year / Month / Day)	
Name of person and their position:	Phone number:
If not reported immediately, give the reason:	
5 Describe fully, based on the information you have, what happened to cause this injury or disease. Please describe what you were doing, including details about any tools, equipment, materials, etc. you were using. State any gas, chemicals or extreme temperatures you may have been exposed to:	

<input type="checkbox"/> Cardiac condition/injury? <input type="checkbox"/> Claimed to another WCB? Province: _____	
<input type="checkbox"/> Motor vehicle accident? If you have a police collision report, please send a copy by mail or fax once you have a claim number. Please also complete the WCB Automobile Accident Report.	
If you have more information or a list of witnesses, please attach a letter. Please check this box if letter is attached. <input type="checkbox"/>	
Have you had a similar injury before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach a letter with details.	
Was the work you were doing for the purpose of your employer's business? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was it part of your usual work? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did the accident/injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location where the accident happened (address, general location or site):	
6 Full name of treating hospital or healthcare professional:	
Address: _____	
Phone: _____	
When did you first seek medical treatment? _____ (Year / Month / Day)	Is any further treatment required? <input type="checkbox"/> Yes <input type="checkbox"/> No



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

Injury Details	What part of body was injured? (hand, eye, back, lungs, etc.)	<input type="checkbox"/> Left side <input type="checkbox"/> Right side
What type of injury is this? (sprain, strain, bruise, etc.)		

Return to Work Details	Please complete all that apply
<input type="checkbox"/> I understand I have a duty to cooperate with WCB in arranging my safe and healthy return to work with my employer.	
7 a. Will/did your employer pay you while off work? <input type="checkbox"/> Yes, pre-accident wages <input type="checkbox"/> Yes, revised rate of pay <input type="checkbox"/> No <input type="checkbox"/> Unknown Revised rate of pay: \$ _____ per _____	
b. Date you first missed work: _____ <small>(Year / Month / Day)</small> c. If you have returned to work indicate date: _____ <small>(Year / Month / Day)</small> Current work status: <input type="checkbox"/> Regular work duties, or <input type="checkbox"/> Modified work duties <input type="checkbox"/> Regular hours of work, or <input type="checkbox"/> Modified hours of work: _____ hrs per _____ If you are working modified duties please describe: _____	
Approximate date you expect to return to work: _____ <small>(Year / Month / Day)</small>	
Is your expected return to work: <input type="checkbox"/> Within 2 weeks <input type="checkbox"/> 2-8 weeks <input type="checkbox"/> 2-6 months <input type="checkbox"/> 6+ months <input type="checkbox"/> Unknown	

Employment Type Details	(Complete A or B or C. Select your type of employment.)
8 A Permanent position employed 12 months of the year: <input type="checkbox"/> Permanent full-time <input type="checkbox"/> Permanent part-time <input type="checkbox"/> Irregular/casual	
or B Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs): <input type="checkbox"/> Seasonal worker <input type="checkbox"/> Summer student <input type="checkbox"/> Temporary position Had this injury not occurred, your last day of employment would have been: Position start: _____ <small>(Year / Month / Day)</small> Position end: _____ <small>(Year / Month / Day)</small> <input type="checkbox"/> Estimated, or <input type="checkbox"/> Actual How many months or days are workers employed in this position? _____	
or C Special employment circumstance: <input type="checkbox"/> Sub contractor <input type="checkbox"/> Vehicle owner/operator <input type="checkbox"/> Welder owner/operator <input type="checkbox"/> Commission <input type="checkbox"/> Piece work <input type="checkbox"/> Volunteer <input type="checkbox"/> Self-employed Do you incur expenses to perform the work (materials, tools, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No Will you receive a T4? <input type="checkbox"/> Yes <input type="checkbox"/> No Note: If you have checked any box in 8C please submit a detailed income and expense statement.	

Earning Details		
a. Your rate of pay at time of accident: \$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		
9 b. Additional taxable benefits: Vacation pay: _____ <input type="checkbox"/> Taken as time off with pay <input type="checkbox"/> Paid on a regular basis % _____ <table style="width:100%; border: none;"> <tr> <td style="width: 20%; border: none;"> <input type="checkbox"/> Shift premium <input type="checkbox"/> Overtime <input type="checkbox"/> Other </td> <td style="border: none;">Please describe:</td> </tr> </table>	<input type="checkbox"/> Shift premium <input type="checkbox"/> Overtime <input type="checkbox"/> Other	Please describe:
<input type="checkbox"/> Shift premium <input type="checkbox"/> Overtime <input type="checkbox"/> Other	Please describe:	
c. Do you have a second job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes – Employer's name: _____ Phone: _____ <small>(Second employer may be contacted)</small>		
d. Did you miss time from this second job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach earning information and time missed details.		



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.

WORKER REPORT

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

Hours of Work Details

10 a. Number of hours (not including overtime): per week

Describe your work schedule (e.g., Monday to Friday, on. Saturday to Sunday, off.):

Declaration and Consent

I declare that the information in the Worker 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 the *Worker Handbook*).
- 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: (Year / Month / Day)

Name (please print): _____

Signature: _____

Signing the above consent enables the Workers' Compensation Board to process your claim.

NOTE: The information required in the *Worker 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*.

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

