

Injury Report Instructions

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

Worker Information

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

Please complete all the information.

Injury or Occupational Disease Information

1 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.

2 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.

3 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.

4 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

6 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.

7 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 that job duties are 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.

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.

Time Lost / Return-to-Work Information

Please complete all the information that applies.

Type of Employment

- 13** 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.

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

14 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.*

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Hours per day:	8D	8D	8D	8D	0	0	0
Hours per day:	8N	8N	8N	8N	8N	8N	0
Hours per day:	8N	8N	8N	8N	8N	0	0

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

D = day • N = night • O = off

Your Last Name: _____ First Name: _____ Initial: _____
 Social Insurance #: _____ Date of Birth: _____ (Year / Month / Day) Phone: _____

Time Lost / Return to Work Information PLEASE COMPLETE ALL THAT APPLY

11 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: _____
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)

12 A Permanent position employed 12 months of the year: Permanent full-time Permanent part-time
 or **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 or 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 **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)

13 a. Your rate of pay at time of accident: \$ _____ Hourly Weekly Bi-weekly Semi-monthly Monthly Other
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

14 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							
Hours per day							
Hours per day							

IMPORTANT
Circle day of injury.
See instructions
c. Date shift cycle commenced _____ (Year / Month / Day)
 or if your schedule is more than 21 days, attach a copy of the schedule.



*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.*



Your Last Name:	First Name:	Initial:
Social Insurance #:	Date of Birth: <small>(Year / Month / Day)</small>	Phone:

Declaration and Consent

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*.

(Year / Month / Day)

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.



PULMONARY HISTORY QUESTIONNAIRE

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

WCB Claim Number
Personal Health Number
Date of Birth (Year / Month / Day)

Worker's (Surname)	(First Name)	(Initials)
Address Street		City/Town
Province		Postal Code
Telephone Number	Current Age	Height
		Weight
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		

1. OCCUPATIONAL HISTORY

Have you ever worked:

A. In a:

	Yes	No	Job Description
1. mine	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. quarry	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. foundry	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. pottery	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. cotton, flax or hemp mill	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. brick plant	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. glass or ceramics factory	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. abrasives factory	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. chemical plants (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

B. With:

	Yes	No	Job Description
1. asbestos	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. a sandblaster	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. coal	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. wood dust	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. uranium	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. grain dust	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

C. With the following:

	Yes	No	If yes, (specify)
1. solvents	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. acids	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. plastics	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. TDI (toluene di-isocyanate)	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. other chemicals, irritants or fumes	<input type="checkbox"/>	<input type="checkbox"/>	_____

2. ILLNESSES

A. Have you ever been told you have any of the following conditions?

	Yes	No	Physician's name, address and telephone number	Reason	Treatment/Test date(s) (Year / Month / Day)
1. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
2. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
3. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
4. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
6. Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
7. Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

2. ILLNESSES (Continued)

	Yes	No	
8. Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	
9. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
10. Eczema	<input type="checkbox"/>	<input type="checkbox"/>	
11. Cancer (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
12. Allergies (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
13. Heart (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
14. Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	

B. Have you ever undergone surgery to your chest, nose, sinuses, or upper abdomen? Yes No

If yes, why _____ when _____

3. FAMILY HISTORY

A. Have any family members suffered from any condition(s) listed in 2A (previous page)? If so, indicate below

Relationship	Condition(s)

4. MEDICAL TREATMENT

A. List occasions on which you visited physician(s) for your current respiratory condition. Attach a separate sheet if necessary.

Physician's name, address and telephone number	Reason	Treatment/Test date(s) <small>(Year / Month / Day)</small>

B. Are you currently taking any medication? (prescribed or "over the counter") Yes No

Name of Medication	Prescribing Doctor

5. LIFESTYLE - Smoking

A. Have you ever smoked cigarettes?

If yes, How many per day? _____

When did you start? _____

Quit? At what age? _____

Have you ever smoked a pipe or cigar on a regular basis? Yes No

6. SYMPTOMS

A. Coughing

Do you cough? Yes No If yes, when? _____

B. Sputum

i) How many times do you bring up phlem per day? _____

ii) What colour is it? _____

iii) Is it ever bloody? Yes No

iv) Thick or Thin

C. Do you have chest pain? Yes No

If yes, i) Where on the chest? _____

ii) What does it feel like? _____

iii) What makes it worse? _____

iv) What makes it better? _____

D. Do you have shortness of breath? _____

If yes, what are you doing at the time? _____

E. Wheezing

When you breathe, is it noisy? Yes No

If yes, in what situations does it happen? _____

Comments

I, the claimant, declare the above information to be true and correct to the best of my knowledge

Date: _____ Name (please print): _____ Signature: _____

WORKER'S EMPLOYMENT RECORD (CHEMICAL EXPOSURE)

WCB Claim Number

Personal Health Number

Worker's (Surname) (First Name) (Initial) Date of Birth (YYYY/MM/DD)

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INSTRUCTIONS

- In completing this form, start with your first employment and proceed to your most recent employment.
- Please type or print clearly in dark (black) ink.

Employer's Name and Address (Street Address, Town/City, Province of Operation)	Employment Period	Occupational Job Duties	Name of Irritants(s)/ Chemicals(s) to which you were exposed	Type of Protective Apparel used
1. _____ _____	From _____ To _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
2. _____ _____	From _____ To _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
3. _____ _____	From _____ To _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
4. _____ _____	From _____ To _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
5. _____ _____	From _____ To _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
6. _____ _____	From _____ To _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

**EXTRACT
FROM
SECTION 28**

THE WORKERS' COMPENSATION ACT

Section 28

- (1) If an accident happens while the worker is employed out of Alberta, the worker or the worker's dependants are entitled to compensation under this Act if
- (a) the worker
 - (i) is a resident of Alberta or
 - (ii) has his or her usual place of employment in Alberta and the work out of Alberta is a continuation of the employment by the same employer or an employer that is related to that employer within the meaning of section 134,
 - (b) the nature of the employment is such that, in the normal course of the employment, the work or service the worker performs is required to be performed both in and out of Alberta and
 - (c) subject to subsection (2), the employment out of Alberta has lasted less than 12 continuous months.
- (2) The Board may, on application by an employer and subject to any terms it considers appropriate,
- (a) waive any of the requirements of subsection (1)(a) and (b), and
 - (b) extend the period referred to in subsection (1)(c)
- (3) If, by the law of the jurisdiction in which the accident happens, the worker or the worker's dependants are entitled to compensation or some other remedy in respect of the accident, the worker or dependants shall elect
- (a) to claim compensation or the other remedy under the law of the other jurisdiction, or
 - (b) to claim compensation under this Act,
- and shall give notice of that election to the Board under subsection (4), but if there is in existence an agreement under section 29, the right of election is subject to the terms of that agreement.
- (4) Subject to subsection (5), notice of election shall be given to the Board
- (a) by the worker within 30 days after the happening of the accident, or
 - (b) if the accident results in death, by a dependant within 30 days after the death,
- and if notice of election is not given in accordance with this subsection, the worker or dependant is deemed to have elected not to claim compensation under this Act.
- (5) The Board may, on application either before or after the expiration of the 30-day period referred to in subsection (4), extend that period.
- (6) If a worker or dependant elects under subsection (3) to claim compensation under this Act and at any time claims compensation or some other remedy under the law of another jurisdiction in respect of the same accident, the worker or dependant is deemed to have forfeited all rights to compensation under this Act in respect of that accident, and any money paid to the worker or dependant or on the worker's or dependant's behalf by the Board in respect of it constitutes a debt due from the worker or dependant to the Board.
- (7) Subsection (6) does not affect the right to compensation of a worker or dependant who takes an action at the request of the Board under section 31.
- (8) Notwithstanding subsection (6), if a worker or dependant, before claiming compensation under this Act, and in ignorance of the worker's or dependant's rights or the extent of the worker's or dependant's rights under this Act, claims compensation under the law of the other jurisdiction where the accident happened and is found to be not entitled to compensation, the worker or dependant is deemed not to have forfeited the worker's or dependant's rights under this Act by reason only of making that claim.



PO Box 2415
Edmonton AB T5J 2S5

C847

ASSIGNMENT OF DAMAGES Workers' Compensation Act, R.S.A. 2000, Chapter W-15

Claim Number _____

I, _____, am entitled to compensation under the *Workers' Compensation Act (the "Act")*, as a result of an accident which occurred on _____ (the "Accident") in which I sustained personal injuries or illness and I understand that I have or may have a right of action outside Alberta in respect of that Accident.

As I have elected to take workers' compensation benefits, I understand the Workers' Compensation Board of Alberta (the "WCB") is entitled to advance any such right of action:

- (a) Pursuant to Section 31 of the *Act* (for accidents prior to December 1st, 2005), or
- (b) Pursuant to Section 22(3) and (9)(c) of the *Act* (for accidents on or after December 1st, 2005).

I HEREBY IRREVOCABLY TRANSFER AND ASSIGN to the WCB all my rights and interest in any such right of action I have or might have as a result of the Accident, including the right to bring and advance any action the WCB may deem appropriate in any jurisdiction in my name, settle or compromise that action, and receive for its own use and benefit all damages resulting therefrom.

Signed in the Province of _____, this _____ day of _____, 20____.

WITNESS SIGNATURE

CLAIMANT SIGNATURE

(printed name and address of witness over age 18)

In order that we may proceed with this claim, please complete and return this form without delay. Please keep one copy for your records.

THE WORKERS' COMPENSATION ACT

Section 31 Accidents prior to December 1, 2005

31(1) If a worker or dependant entitled to compensation under this Act has a right of action in a jurisdiction other than Alberta in respect of personal injury to or death of the worker,

- (a) the Board may request the worker or dependant to take an action in that other jurisdiction, and
- (b) the worker or dependant shall assign the worker's or dependant's right to damages recoverable, and all damages that the worker or dependant recovers, under that action to the Board

and the Board may withhold payment of compensation to the worker or dependant until the worker or dependant takes the action or makes the assignment, as the case may be.

(2) If the Board requests the worker or dependant to take an action in another jurisdiction, it shall repay to the worker or dependant the costs necessarily incurred by the worker or dependant in the prosecution of the action, but the Board is not required to pay the costs of any appeal unless the appeal is taken at the request or with the approval of the Board.

Section 22 (3) Accidents after December 1, 2005

22(3) Notwithstanding any other Act, if an accident happens to a worker entitling a claimant to compensation under this Act, any action of the claimant in respect of that accident vests in the Board.

Section 22 (9) Accidents after December 1, 2005

22(9) The claimant shall not adversely affect the conduct of an action and shall co-operate fully with the Board in bringing an action or any appeal of an action including, without limitation, by

- (a) securing and providing any or all information or evidence,
- (b) attending at any or all meetings, mediations, arbitrations, examinations for discovery, medical examinations, including independent medical examinations, and the trial of the action, and
- (c) providing and executing any or all documents required by the Board to bring the action, including endorsing an assignment or release of the action and providing consents to secure information, in the form and manner prescribed by the Board, in favour of the Board,

as and when required by the Board.