



**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

January 2010  
**EMPLOYER'S REPORT**  
of Injury or Occupational Disease C040

Seven Digit Claim #:  
(if available)

<b>Claim Type</b>	<input type="checkbox"/> Time Lost	<input type="checkbox"/> Modified Work	<input type="checkbox"/> Fatality	<input type="checkbox"/> No Time Lost (Notice of non-disabling injury/illness)
	Complete entire report if claim type is one of the above			

**Worker Information**

Last Name:	Former Name: (e.g., maiden name)	First Name:	Initial:
Address:	Apt #:	Social Insurance #:	
City:	Province:	Postal Code:	Health Care #:
Daytime Phone:	Evening Phone:	Date of Birth: (Year / Month / Day)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Occupation:	Apprentice: <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Employer Information**

Business Name or Government Department:	WCB Account Number:	Industry:
Mailing Address:	Does the injured worker have WCB personal coverage with this business?	<input type="checkbox"/> Yes <input type="checkbox"/> No
City:	Is injured worker a proprietor, partner or director in this business?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Province:	Postal Code:	Employer/Supervisor Contact Name:
Phone:	Fax:	Phone:
		E-mail Address:

**Injury or Occupational Disease information**

Date and time of injury: (Year / Month / Day) Time:  a.m.  p.m.  This condition developed over a period of time.

Scheduled hours of employment on the day of accident: From: To:

When was someone at your business notified of the injury? (Year / Month / Day) Time:  a.m.  p.m.

Name of person and their position: Contact Information:

Did the injury occur on employer's premises?  Yes  No Did injury occur in Alberta?  Yes  No

Location where the accident happened (address or general location):

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have more information, please attach a letter. Letter attached?  Yes  No

What part of body injured? (hand, eye, back, lungs, etc.)  Left side  Right side

What type of injury is this? (sprain, strain, bruise, etc.)

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

Check the box that best describes the physical demands of the regular duties:  Sedentary  Light  Medium  Heavy  Very Heavy  
(See detailed description on page 2 of attached instructions)

Indicate type of aid provided:  First aid  Medical aid (Name of treating healthcare professional/hospital): \_\_\_\_\_  None

Was a copy of this report given to the injured worker as per the *Workers' Compensation Act*?  Yes  No  Worker declined it

Employer's Signature: \_\_\_\_\_ Date: (Year / Month / Day)

(for office use only)



Worker's Last Name:	Worker's First Name:	Initial:
Social Insurance #:	Date of Birth:	(Year / Month / Day)

### Lost Time/Return to Work Information

a. Date and time worker first missed work: \_\_\_\_\_ (Year / Month / Day) Time:  a.m.  p.m.

b. Will/did you pay the worker while off work?  Yes  No

If yes, will/did you pay:  Pre-accident rate of pay and hours of work  Other Rate: \$ \_\_\_\_\_ per \_\_\_\_\_, or Number of hours: \_\_\_\_\_ per \_\_\_\_\_, or gross amount: \$ \_\_\_\_\_

For the period from: \_\_\_\_\_ (Year / Month / Day) to \_\_\_\_\_ (Year / Month / Day)

c. If the worker has returned to work indicate date: \_\_\_\_\_ (Year / Month / Day) Time:  a.m.  p.m.

Check:  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 \_\_\_\_\_

d. 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

### Type of Employment (Complete A or B or C)

**A**  Permanent position employed 12 months of the year:  Full-time  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  Volunteer  Summer student

Had this injury not occurred the worker's last day of employment would have been: \_\_\_\_\_ (Year / Month / Day)  Estimated or  Actual

How many months or days per year do you employ people in this position? \_\_\_\_\_

or **C** Special employment circumstance:  Contractor/sub contractor  Vehicle owner/operator  Welder owner/operator  Commission

Piece work  Other/self-employed

Does the worker incur expenses to perform the work (materials, tools, etc.)?  Yes  No Will the worker receive a T4?  Yes  No

**Note: If you have checked any box in 11C, have the worker submit a detailed income and expense statement.**

### Wage Information

Date the worker was hired: \_\_\_\_\_ (Year / Month / Day)

a. Worker's 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

a. Gross earnings for the period of one year or date the worker was hired if less than one year: \$ \_\_\_\_\_ from: \_\_\_\_\_ (Year / Month / Day) to: \_\_\_\_\_ (Year / Month / Day)

(12 months or less prior) (date of injury)

b. Was any time missed from work **without pay** during the above period, excluding vacation? (eg. maternity, sick, work shutdown, WCB benefits)  Yes  No

If yes, number of days: \_\_\_\_\_ Reason: \_\_\_\_\_

### Hours of Work

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):

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Average hours worked per week: _____	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 the worker's schedule is more than 21 days, attach a copy of schedule.

Earnings Information Contact (please print): \_\_\_\_\_ Phone Number: \_\_\_\_\_