

Employer's Report

of Injury or Occupational Disease

JUNE 2011

Important Information

How soon should you report injuries to WCB?

- As soon as possible. Research shows the longer the delay in reporting and managing an injury, the higher the claim costs. If you fail to report an injury within 72 hours after receiving notice or knowledge of the injury, you may be penalized up to \$25,000.
- Complete and send the attached *Employer's Report* to WCB or if you are a current *myWCB* user report online at www.wcb.ab.ca.
- Provide a copy of the first aid record to your worker.

What injuries should you report to WCB?

- Work-related injuries that cause (or are likely to cause) your worker to be off work beyond the day of the injury.
- Injuries that require modified work beyond the day of the injury.
- Injuries that require medical treatment beyond first aid (e.g., physical therapy, prescription medications, chiropractic).
- Injuries that may result in a permanent disability (e.g., amputations, hearing loss).

What if I have additional information or concerns?

- Send us a letter to help us make a decision about the claim. Check the box in number 6 of the form indicating you have attached a letter. Include names, telephone numbers, and statements of any witnesses.

Important: If you send a letter, please include your worker's name and Social Insurance Number, your company's name, and your signature.

To report an injury

Electronic: Visit *myWCB Online Services for Employers* at www.wcb.ab.ca. Request access online or, if you are a current user, log on to our secure connection with your user ID and password.

Fax: **780-427-5863** (Edmonton) or **1-800-661-1993**
If you fax the report, do not send another copy by mail.

Mail to: WCB, PO Box 2415
Edmonton AB T5J 2S5

Any questions?

Edmonton: **780-498-3999**

Calgary: **403-517-6000**

**Toll Free
in Alberta:** **1-866-922-9221**

**Toll Free
outside Alberta:** **1-800-661-9608**

8 a.m. - 4:30 p.m. Monday through Friday



Workers'
Compensation
Board

Alberta

Employer's Report Instructions

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

If you are unclear or need assistance completing this form, call 780-498-3999.

Claim Type

1 Time Lost (TL)

Check this box if your worker is off work past the day of the injury. (Complete both pages of the form.)

Modified Work

Check this box if your worker's duties have changed because of the injury. Modified work includes a change in duties, job, hours, or amount of work. If your worker is on modified work beyond the day of the accident, the injury must be reported to WCB even if there is no time lost or loss of earnings. (Complete both pages of the form.)

No Time Lost (NTL)

Check this box if your worker will not miss work beyond the day of the injury. (Complete the first page only of the form.)

Worker Information

Please provide as much information as possible.

Employer Information

2 Employer contact

Provide the contact name and number of the person in your company managing your worker's claim and return to work.

Injury or Occupational Disease Information

3 Date & time of injury

If the injury/condition or occupational disease developed over a period of time, indicate the date you first became aware of the injury.

4 When was someone notified of the injury?

Name the date, time, person, position and contact information.

5 Location of accident

This information may be needed to determine:

- whether your worker was performing duties in the course of employment, *OR*
- whether the injury occurred due to the negligence of another party.

Provide a street address, if possible, indicate the location (e.g., 25 km east of Edmonton on Highway 16, an oil rig site). If it is a motor vehicle accident, include the direction of travel.

6 Describe what happened to cause the injury

Include typical actions and how often they are repeated on the job (e.g., twisting, typing, pushing, and pulling). If there is any lifting, indicate the weight.

If you need more space than the area provided, please attach a letter.

Example:

Bob walked into our walk-in cooler to get a 50 lb. sack of potatoes. He bent down and picked up the sack, turned to his right to leave. He felt a pull in his lower back and dropped the potatoes on his right foot, also injuring his right foot.

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 what 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.

7 Physical Demands of the job

Sedentary

- Lifting 10 lbs maximum
- Occasional lifting/carrying
- Primarily sitting, with occasional walking/standing

Light

- Lifting 20 lbs maximum
- Frequent lifting/carrying up to 10 lbs
- May require walking/standing to a significant degree
- 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

Please fill in your worker's name, Social Insurance Number, and date of birth at the top of the second page in case the pages get separated.

Time Lost/Return to Work Information

- 8** Please fill out all of the information that applies.

Type of Employment

- 9** Complete one of the following A or B or C

- **Complete A** if your worker works for you 12 months per year.
- **Complete B** if your worker works only part of the year, even though you may call him/her back to work each year. To correctly set the amount of compensation, we need to know the total number of days or months per year you would employ someone doing the same job as the injured worker, even if the work period starts and ends several times.
- **Complete C** if the injured person is a contractor, subcontractor, or does piecework. They must send detailed income and expense information.

Wage Information

- 10** b. Additional taxable benefits

Vacation and statutory holiday pay

Please indicate if your worker is paid holiday and stat pay as an additional percentage on their paycheque (therefore must take these days off without pay) or, these days are included as days off with pay.

Shift premiums

Complete if your worker receives pay in addition to the regular rate of pay (e.g., 50¢ paid per hour for night shift). If your worker receives 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 your worker works regular overtime throughout the year.

Other

Use this if your worker gets any other taxable benefits (e.g., permanent accommodation, company car, northern living allowance).

- 11** a. Gross earnings

Provide the gross earnings for your worker for the one year period prior to the injury (less if they have not worked a full year).

Example:

Your worker was injured on June 4, 2007. Provide gross earnings for the period June 4, 2006 to June 3, 2007. A T4 slip for the previous year is not sufficient. If employment lasts less than one year or worked on a seasonal or casual basis, provide the total gross earnings for the entire period worked prior to the injury.

b. Time missed from work without pay

These are periods your worker missed because of work shutdown, maternity leave, or sick leave without pay. Do not include vacation periods.

Hours of Work

- 12** a. Number of Hours

Indicate the regular hours of work, not including overtime periods.

b. Does 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 worked per day in each of the boxes. Put zero for days off. 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 your worker was injured to determine the compensation to pay.

See example below.

OR:

If the work schedule is longer than **21 calendar days**, attach a copy of the schedule. Circle the day on this work schedule that your worker was injured.

Example: Your worker worked 8-hour days in the first week and 8-hour nights in the second and third weeks. Your worker was injured on the Wednesday of the second week and was off work for 2 days (Thursday and Friday). Your worker would be paid WCB benefits for 2 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 your worker was injured.



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)

Claim Type	1 <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	Complete first page only

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:	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:	2 Employer/Supervisor Contact Name:	
Phone:	Fax:	Phone:	
		E-mail Address:	

Injury or Occupational Disease information			
3 Date and time of injury:	(Year / Month / Day)	Time:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> This condition developed over a period of time.
Scheduled hours of employment on the day of accident:		From:	To:
4 When was someone at your business notified of the injury?	(Year / Month / Day)	Time:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Name of person and their position:		Contact Information:	
Did the injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury occur in Alberta? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5 Location where the accident happened (address or general location):			
6 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What part of body 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.)			
Were the worker's actions at the time of injury for the purpose of your business?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Were the actions part of the worker's regular duties?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
7 Check the box that best describes the physical demands of the regular duties: <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy (See detailed description on page 2 of attached instructions)			
Indicate type of aid provided: <input type="checkbox"/> First aid <input type="checkbox"/> Medical aid (Name of treating healthcare professional/hospital): _____ <input type="checkbox"/> 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)



C 0 4 0 C-040 REV JAN 2010

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.

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

8 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

9 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:

10 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

11 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

12 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
Hours per day:							
Hours per day:							
Hours per day:							

Average hours worked per week: _____

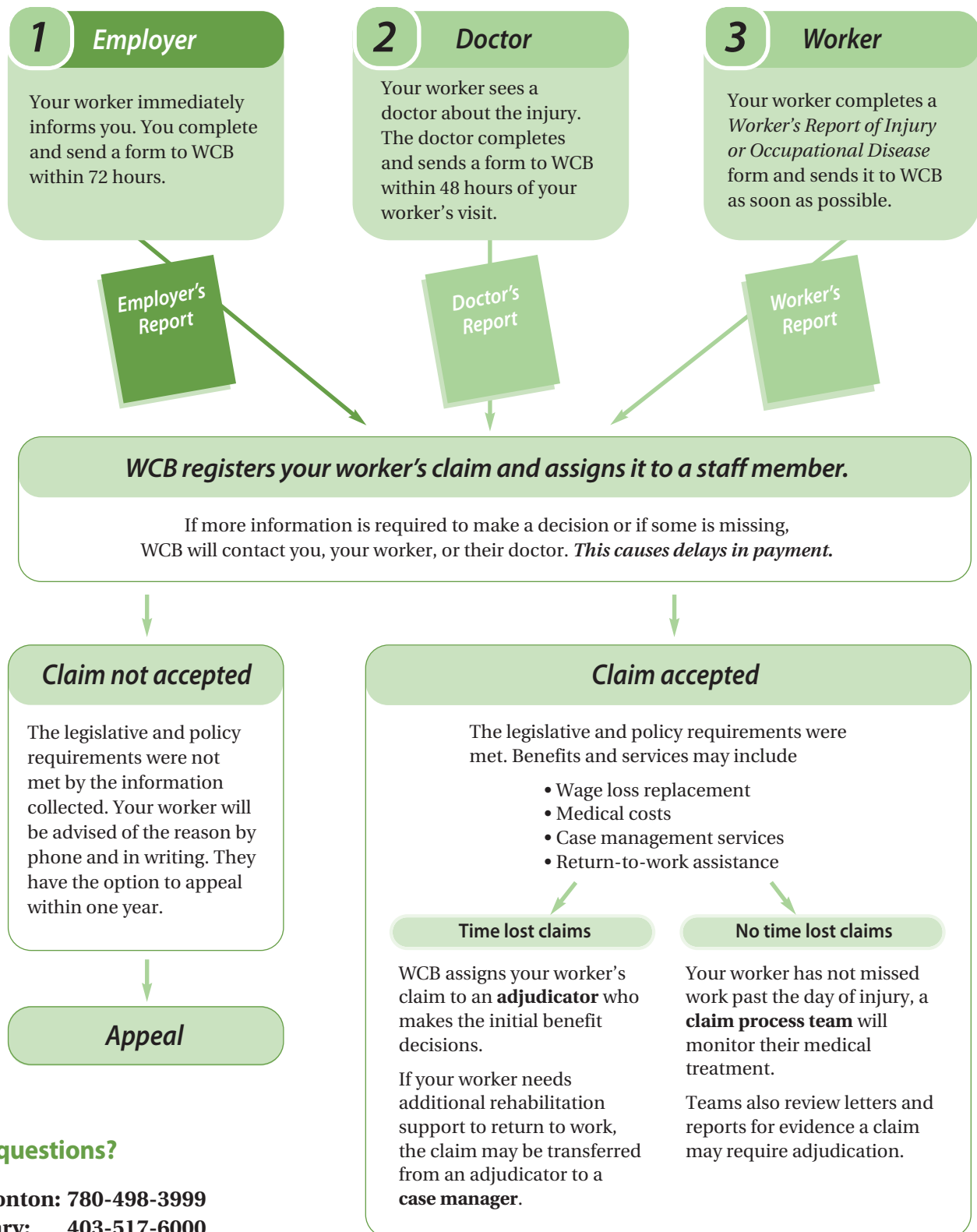
c. Date shift cycle commenced: _____ (Year / Month / Day)

IMPORTANT: Circle day of injury. See instructions

or If the worker's schedule is more than 21 days, attach a copy of schedule.

Earnings Information Contact (please print): _____ Phone Number: _____

What happens when your worker is injured at work?



Any questions?

Edmonton: 780-498-3999
Calgary: 403-517-6000
Toll Free: 1-866-922-9221

