Injury Report Instructions

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

Workers' Compensation Board
Alberta

Worker Details

1 Have your work duties been modified?

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 Details

2 Please complete all the information.

Accident Details

3 Date and time of accident

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.

4 Date accident/injury reported to employer

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.

5 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 the job duties 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. Fill out the Automobile Accident Report in this booklet.

6 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.

Injury Details

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.

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**

September 2014

WORKER REPORT

of Injury or Occupational Disease C060

Seven Digit Claim #:

Worker Details

Past the date of injury: Have you been off work? ☐ Yes ☐ No

① Have your work duties been modified? ☐ Yes ☐ 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: ☐ M ☐ F

Occupation and job description:

Are you an apprentice? ☐ Yes ☐ 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? ☐ Yes ☐ No

Do you have personal coverage? ☐ Yes ☐ 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: __ __ : __ __ ☐ a.m. ☐ p.m. *or* ☐ the injury/condition developed over time

Date/time scheduled shift started (if applicable): (Year / Month / Day) Time: __ __ : __ __ ☐ a.m. ☐ p.m.

Date/time scheduled shift ended (if applicable): (Year / Month / Day) Time: __ __ : __ __ ☐ a.m. ☐ 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:

____

____

____

____

☐ Motor vehicle accident? ☐ Cardiac condition/injury? ☐ Claimed to another WCB? Province: ____________________

If you have more information or a list of witnesses, please attach a letter. Please check this box if letter is attached. ☐

Have you had a similar injury before? ☐ Yes ☐ No **If yes, attach a letter with details.**

Was the work you were doing for the purpose of your employer's business? ☐ Yes ☐ No Was it part of your usual work? ☐ Yes ☐ No

Did the accident/injury occur on employer's premises? ☐ Yes ☐ No

⑥ Location where the accident happened (address, general location or site):

Full name of treating hospital or healthcare professional:

Address:

Phone:

Injury Details

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

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

Complete all three pages and sign the form before sending.

If your injury is the result of a motor vehicle accident, complete the Motor Vehicle Accident Report (L-054).

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.

7 Return-to-Work Details

Please complete all the information that applies.

Employment Details

8 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.

Earnings Details

9 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 or, if these days are included as days off with pay.

Shift premiums
Complete if you receive pay in addition to your regular rate of pay (e.g., 50¢ paid per hour for night shift). Provide your gross shift premium earnings for one year prior to the date of injury (less if you have not worked a full year).

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 Details

10 a) Number of hours

Indicate your regular hours of work.
Do not include overtime here.

Worker's Last Name: Worker's First Name: Initial:

Social Insurance #: Date of Birth: (Year / Month / Day)

Return to Work Details

Please complete all that apply

7 a. Will/did your employer pay you while off work? ☐ No ☐ Yes, pre-accident wages ☐ Unknown

b. Date and time you first missed work: (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

c. If you have returned to work indicate date: (Year / Month / Day) Time: ___ ___ : ___ ___ ☐ a.m. ☐ p.m.

Current work status: ☐ 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 ________

If you are working modified duties please describe:

Employment Type Details

(Complete A or B or C. Select your type of employment.)

8 **A** Permanent position employed 12 months of the year:

☐ Permanent full-time ☐ Permanent part-time ☐ Irregular/casual

or **B** Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs):

☐ Seasonal worker ☐ Summer student ☐ Temporary position

Had this injury not occurred, your last day of employment would have been:

Position start: (Year / Month / Day) Position end: (Year / Month / Day) ☐ Estimated, *or* ☐ Actual

How many months or days are workers employed in this position? _____________

or **C** Special employment circumstance:

☐ Sub contractor ☐ Vehicle owner/operator ☐ Welder owner/operator ☐ Commission ☐ Piece work ☐ Volunteer ☐ 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 8C please submit a detailed income and expense statement.

Earning Details

a. Your rate of pay at time of accident: $ ☐ per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year

9 b. Additional taxable benefits:

Vacation Pay: _____________ ☐ Taken as time off with pay ☐ Paid on a regular basis % ☐

☐ Shift Premium
☐ Overtime
☐ Other

Please describe:

c. Do you have a second job? *(Second employer may be contacted)* ☐ Yes ☐ No If yes – Employer's Name: Phone:

d. Did you miss time from this second job? ☐ Yes ☐ No If yes, please attach earning information and time missed details.

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.):

Complete all three pages and sign the form before sending.

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

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*.

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.

WCB Workers' Compensation Board Alberta

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

C013

PULMONARY HISTORY QUESTIONNAIRE

WCB Claim Number

Personal Health Number

Worker's *(Surname)* *(First Name)* *(Initials)*

Date of Birth *(Year / Month / Day)*

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

Postal Code

Telephone Number ( )

Current Age

Height

Weight

Gender ☐ Male ☐ Female

1. OCCUPATIONAL HISTORY

Have you ever worked:

A. In a:

	Yes	No	Job Description
1. mine	☐	☐	
2. quarry	☐	☐	
3. foundry	☐	☐	
4. pottery	☐	☐	
5. cotton, flax or hemp mill	☐	☐	
6. brick plant	☐	☐	
7. glass or ceramics factory	☐	☐	
8. abrasives factory	☐	☐	
9. chemical plants *(specify)* ______			
10. other *(specify)* ______			

B. With:

	Yes	No	Job Description
1. asbestos	☐	☐	
2. a sandblaster	☐	☐	
3. coal	☐	☐	
4. wood dust	☐	☐	
5. uranium	☐	☐	
6. grain dust	☐	☐	
7. other *(specify)* ______	☐	☐	

C. With the following:

	Yes	No	If yes, *(specify)*
1. solvents	☐	☐	
2. acids	☐	☐	
3. plastics	☐	☐	
4. TDI (toluene di-isocynate)	☐	☐	
5. other chemicals, irritants or fumes	☐	☐	

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	☐	☐			
2. Emphysema	☐	☐			
3. Chronic bronchitis	☐	☐			
4. Pneumonia	☐	☐			
5. Tuberculosis	☐	☐			
6. Pleurisy	☐	☐			
7. Sinusitis	☐	☐			

Worker's *Surname*	*First Name*	*Initial*	WCB Claim Number

2. ILLNESSES (Continued)

	Yes	No		
8. Pneumothorax	☐	☐		
9. Diabetes	☐	☐		
10. Eczema	☐	☐		
11. Cancer (specify)	☐	☐		
12. Allergies (specify)	☐	☐		
13. Heart (specify)	☐	☐		
14. Other (specify)	☐	☐		

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) *(Year / Month / Day)*

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

Worker's *Surname*	*First Name*	*Initial*	WCB Claim Number

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:

Workers' Compensation Board
Alberta

C117

WORKER'S EMPLOYMENT RECORD (CHEMICAL EXPOSURE)

WCB Claim Number

Personal Health Number

Worker's *(Surname)* *(First Name)* *(Initial)*

Date of Birth (YYYY/MM/DD)

Page of

INSTRUCTIONS

1. *In completing this form, start with your first employment and proceed to your most recent employment.*
2. *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			

THE WORKERS' COMPENSATION BOARD BOX 2415 EDMONTON AB T5J 2S5	File No.	Class	Claim No.	Accident date	LBR. Code
IN ORDER THAT WE MAY PROCEED WITH THIS CLAIM, PLEASE COMPLETE AND RETURN THIS FORM WITHOUT DELAY.	To: Worker's Name and Address Employer's Name and Address				

Note section of Act printed on reverse ➞

We have received reports that you were injured on the date shown above in an industrial accident outside of Alberta.

You may have the right to claim compensation under the provisions of Section 28 of The Workers' Compensation Act of Alberta, (see reverse) or alternately to claim compensation or other remedy under the law of the place in which you were injured.

You should consider this matter carefully and, if you decide to claim compensation under the Alberta Act, you should (a) complete and return the enclosed application form, and (b) complete the election portion of this form and return it.

If we have not heard from you within thirty days, we will assume that you do not wish to claim under The Workers' Compensation Act of Alberta and we will take no further action in this matter.

ELECTION TO CLAIM UNDER THE ACT

In the matter of injuries resulting from an accident that happened on ____________________ at or near _________________ I elect to claim compensation under The Workers' Compensation Act of the Province of Alberta.

I have read and understand the provisions of Section 28 of the Act.

Signed _____________________________

C – 169 REV SEPT 2003

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 forefeited 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.