

# Employer Report of Injury

## Reporting an injury

By law, employers are required to report injuries that their workers suffer while on the job. If your worker has been injured, you have **72 hours** after becoming aware of an injury or illness to submit the Employer Report of Injury form. The sooner we receive your information, the faster we can determine entitlement to benefits and services for your worker.

### You must submit a report to WCB if the accident results in, or is likely to result in:

- **lost time or the need to temporarily or permanently modify work** beyond the date of accident
- **death or permanent disability** (amputation, hearing loss, etc.)
- **a disabling or potentially disabling condition** caused by occupational exposure or activity (poisoning, infection, respiratory disease, dermatitis, etc.)
- **the need for medical treatment beyond first aid** (assessment by physician, physiotherapy, chiropractic, etc.)
- **incurring medical aid expenses** (dental treatment, eyeglass repair or replacement, prescription medications, etc.)



#### Option 1: Report online using myWCB

myWCB provides you with access to a number of online services, including reporting. Through myWCB, electronic injury reporting will guide you through the reporting process and provide you with help along the way.

To learn more about myWCB, visit our website under [Resources > For employers > Online services](#).



#### Option 3: Report by fax

If you are unable to access our online services you can submit the Employer Report of Injury form by fax to:

780-427-5863 (Edmonton)  
1-800-661-1993 (within Canada)

If you fax the report, do not send another copy by mail.



#### Option 2: Submit a one-time injury report

If you are unable to sign up for online services you can still submit a one-time injury report online.

Visit our website under [Claims > Report an injury > For employers](#).

#### If you have questions or need help reporting, call us.

Inside Alberta: 1-866-922-9221  
Outside Alberta: 1-800-661-9608 (in Canada)

# Employer 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 only the first page of the form.)

## Worker Details

Please provide as much information as possible.

## Employer Details

### 2 Employer/supervisor contact

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

## Accident Details

### 3 Date & time of accident

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

### 4 Date accident/injury reported to employer

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

### 5 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.*

### 6 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.

### 7 Employer provided health benefits

Employers are required to pay the health benefits of their injured workers for up to one year\* following the date of accident. If your worker was contributing to any premiums, they must also continue to pay what they were paying before the accident or illness for benefit coverage to continue.

*\*If your worker voluntarily ends their employment during the coverage period, you will no longer be entitled to provide health benefits past the last day of employment.*

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.

Seven digit claim # (if available):

<b>Claim Type</b>	<b>1</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	Complete first page only

**Worker Details**

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
Occupation:		Job description:		Date hired: (Year / Month / Day)	
Does the worker have WCB personal coverage with this business? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is the worker a partner or director in this business? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the worker an apprentice? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date the worker would have obtained journeyman status: (Year / Month / Day)			

**Employer Details**

Business name or government department:		WCB account number:		Industry:	
Mailing address:		<b>2</b> Employer/Supervisor contact name and title:			
City:					
Province:		Postal code:		Contact phone:	
Phone:		Fax:		Contact e-mail:	

**Accident Details**

<b>3</b> Date and 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 and time scheduled shift started: (Year / Month / Day)	Time: ____:____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Date and time scheduled shift ended: (Year / Month / Day)	Time: ____:____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
<b>4</b> Date accident/injury reported to employer: (Year / Month / Day)		
To whom was the accident/injury reported?:		Phone number:
<b>5</b> 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:		
<hr/> <hr/> <hr/>		
Motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If you have a police collision report, please mail or fax it to us once you have a claim number available. Please include the worker's name and claim number.		If you have more information, please attach a letter. Letter attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac condition/injury? <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
<b>6</b> Location where the accident happened (address, general location or site):		
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
<b>7</b> Did you provide health benefits to the worker at the time of the accident?		
If yes, will you continue to pay the health benefit premium?		<input type="checkbox"/> Yes <input type="checkbox"/> No





## Page two of form

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.

### Return to Work Details

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

### Employment Type Details

- 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 the worker 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 an owner/operator, subcontractor, or does piece work.

### Earnings Details

- 10** Complete one of the following A or B

#### A. Gross earnings

Provide the worker's gross earnings for the 1 year period prior to the date of injury; or from the date the worker received a pay raise or job change in the past year; or from the date the worker was hired if less than 1 year from the date of injury.

#### Example:

*Your worker was injured on June 4, 2014. Provide gross earnings for the period June 4, 2013 to June 3, 2014. A T4 slip for the previous year is not sufficient.*

#### Gross earnings include:

- Basic hourly, weekly, biweekly, or monthly pay
- Overtime pay
- Shift differentials
- Bonuses
- Statutory Holiday pay
- Gratuities
- The dollar value of the employer-subsidized portion of employer-provided accommodation if the worker loses the accommodation because of the accident.
- The dollar value of an isolation allowance if the allowance is a permanent part of the job and the worker loses the allowance because of the compensable accident.
- The dollar value of travel, subsistence and lodging allowances if they are recorded as taxable benefits.

#### Gross earnings not to include:

- Non-taxable income
- Severance Pay
- Pay in Lieu of Notice
- Reimbursement of Expenses
- Employer paid RRSP/RPP contributions
- Employer paid AHC premiums
- Employer paid group insurance premiums
- Dividend income

#### Time missed from work without pay

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

#### B. Hourly Rate

##### 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 or if these days are taken as time 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). Provide the worker's gross shift premium earnings for the one year prior to the date of injury (less if they have not worked a full year).

##### Overtime

Complete only if your worker works overtime throughout the year.

##### Other

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

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

<b>Injury Details</b>	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.)		

**8 Return to Work Details**

<input type="checkbox"/> I understand that I have a legal obligation to work with my injured worker and WCB to coordinate his/her safe return to work. I am also obligated to hold the worker's job while he/she recovers. Exceptions: Short-term or some seasonal workers, subcontractors and workers with personal coverage.		
a. Will/Did you pay the worker regular pay while off work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the worker returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Date worker first missed work:	<small>(Year / Month / Day)</small>	
c. If the worker has 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 _____		
<input type="checkbox"/> Pre-accident rate of pay, or <input type="checkbox"/> Revised rate of pay: \$ _____ per _____ <input type="checkbox"/> Not working		
d. Has modified work been offered? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please describe the modified duties offered or currently performing:		
Do you need assistance identifying modified work opportunities? <input type="checkbox"/> Yes <input type="checkbox"/> No		
e. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Was offered but the worker declined		
f. Approximate return to work date:	<small>(Year / Month / Day)</small>	

**9 Employment Type Details (Complete A or B or C. Select the worker's type of employment.)**

<b>A</b> <input type="checkbox"/> Permanent position employed 12 months of the year: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Irregular/Casual
or <b>B</b> <input type="checkbox"/> 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 start date: <small>(Year / Month / Day)</small> Position end date: <small>(Year / Month / Day)</small> <input type="checkbox"/> Estimated <input type="checkbox"/> Actual
How many months or days per year do you employ workers in this position?
or <b>C</b> Alternate employment: <input type="checkbox"/> Sub contractor <input type="checkbox"/> Piece work <input type="checkbox"/> Vehicle owner/operator <input type="checkbox"/> Welder owner/operator
<input type="checkbox"/> Self-employed <input type="checkbox"/> Volunteer <input type="checkbox"/> Commission <input type="checkbox"/> Other
Does the worker incur expenses to perform the work (substantial materials, heavy equipment, larger tools, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Will the worker receive a T4? <input type="checkbox"/> Yes <input type="checkbox"/> No

**10 Earnings Details Choose A or B:**

Earnings information contact name (please print):

Earnings contact phone number:	Earnings contact e-mail:
<b>A</b> Gross earnings for the period of one year prior to the date of injury or date the worker was hired if less than one year: \$ _____ from: <small>(Year / Month / Day)</small> to: <small>(Year / Month / Day)</small>	
Was any time missed from work <b>without pay</b> during the above period, excluding vacation? (eg. maternity, sick, WCB benefits) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dates and reasons:	
or <b>B</b> Worker's hourly rate of pay at time of accident: \$ _____	
Additional taxable benefits:	
Vacation pay <input type="checkbox"/> Taken as time off with pay   OR <input type="checkbox"/> Paid on a regular basis   % _____	
Shift premium gross earnings: \$ _____	from: <small>(Year / Month / Day)</small> to: <small>(Year / Month / Day)</small>
Overtime gross earnings: \$ _____	from: <small>(Year / Month / Day)</small> to: <small>(Year / Month / Day)</small>
Other gross earnings: \$ _____	from: <small>(Year / Month / Day)</small> to: <small>(Year / Month / Day)</small>



Please fill in your worker's 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.

EMPLOYER REPORT

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

**11 Hours of Work Details**

a. Number of hours (not including overtime):  per  Day  Week  Shift cycle  Other: \_\_\_\_\_

b. Does the work schedule repeat?  
 No  Yes →

↓  
 Average regular hours worked per week (not including overtime):

Date shift cycle commenced: (Year / Month / Day)

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hours per day:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hours per day:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Mark hours worked for one complete work schedule (use zero for days off):**

**IMPORTANT Circle day of injury. See instructions**

*or if your schedule is more than 21 days, attach a copy of the schedule.*

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

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.**

## Hours of Work Details

### 11 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 regular hours worked per week during the year prior to the injury. Do NOT complete the work schedule.

#### If Yes:

Mark the number of regular 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. Circle the day in the work schedule your worker was injured.

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	Thur	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.

## Notes:

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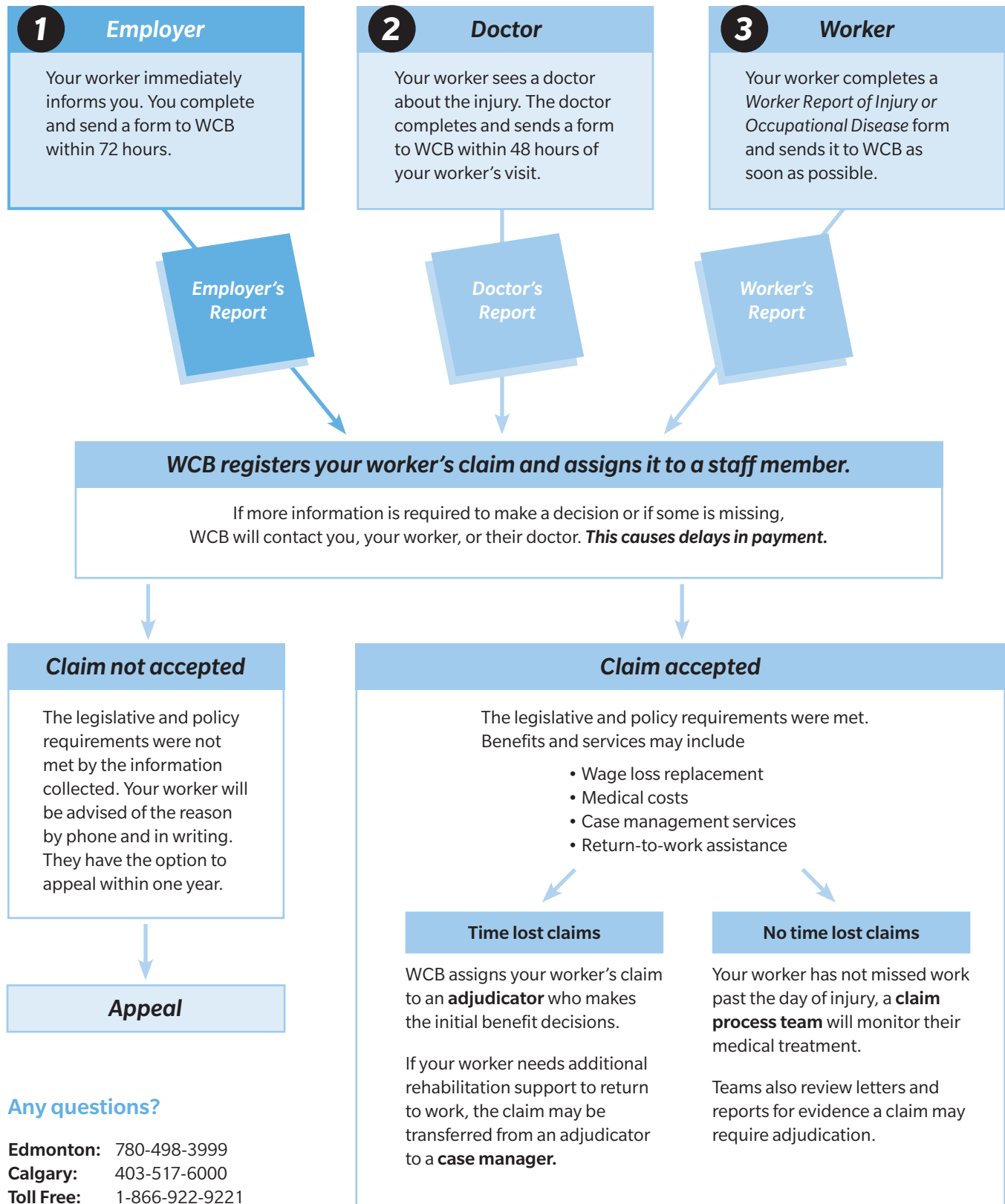


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# What happens when your worker is injured at work?



## Any questions?

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