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 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 (within Canada). 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
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.

Page 2 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

7 Please fill out all of the information that applies.

Employment Type Details

8 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**

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

**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).

**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.

**Hours of Work Details**

**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.

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Important: Circle the day in the work schedule your worker was injured.
**Employer Details**

Business Name or Government Department: 
WCB Account Number: 
Industry: 

Employer/Supervisor Contact Name and Title: 
Mailing Address: 
City: Province: Postal Code: 
Phone: Fax: Contact Phone: Contact E-mail: 

**Accident Details**

Date/time of accident: (Year / Month / Day) Time: ___ : ___ a.m. ___ p.m. or the injury/condition developed over time

Date/time scheduled shift started: (Year / Month / Day) Time: ___ : ___ a.m. ___ p.m.

Date/time scheduled shift ended: (Year / Month / Day) Time: ___ : ___ a.m. ___ p.m.

Date accident/injury reported to employer: (Year / Month / Day) 

To whom was the accident/injury reported?: Phone Number: 

**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.)

Employer’s Signature: Date: (Year / Month / Day)
EMPLOYER REPORT

Worker's Last Name: ___________________________ Worker's First Name: ___________________________
Social Insurance #: ___________________________ Date of Birth: ___________________________

7 Return to Work Details

a. Will/did you pay the worker regular pay while off work? [ ] Yes [ ] No

b. Date and time worker first missed work: ___________________________ ___________________________

    Time: _____ : _____ a.m. [ ] p.m.

c. If the worker has returned to work, indicate date: ___________________________ ___________________________

    Time: _____ : _____ a.m. [ ] p.m.

   Current work status: [ ] Regular work duties, [ ] 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 the worker is working modified duties, please describe:

d. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? [ ] Yes [ ] No

e. Approximate return to work date: ___________________________ ___________________________

    Does the worker have more than one position at your company? [ ] Yes [ ] No

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

A [ ] Permanent position employed 12 months of the year: [ ] Full Time [ ] 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 start date: ___________________________ ___________________________

    Position end date: ___________________________ ___________________________

    Estimated [ ] Actual

How many months or days per year do you employ workers in this position?

or C [ ] Sub contractor [ ] Piece work [ ] Vehicle owner/operator [ ] Welder owner/operator

[ ] Self-employed [ ] Volunteer [ ] Commission [ ] Other

Does the worker incur expenses to perform the work (substantial materials, heavy equipment, larger tools, etc.)? [ ] Yes [ ] No

Will the worker receive a T4? [ ] Yes [ ] No

9 Earnings Details

Earnings information contact name (please print): ___________________________

Earnings contact phone number: ___________________________

    Earnings contact e-mail: ___________________________

Choose A or B:

A 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: ___________________________ to: ___________________________

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

Dates and reasons:

or B Worker’s hourly rate of pay at time of accident: $ ___________________________

Additional taxable benefits:

Vacation Pay [ ] Taken as time off with pay OR [ ] Paid on a regular basis %

Shift Premium Gross earnings: $ ___________________________ from: ___________________________ to: ___________________________

Overtime Gross earnings: $ ___________________________ from: ___________________________ to: ___________________________

Other Gross earnings: $ ___________________________ from: ___________________________ to: ___________________________

10 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: ___________________________ ___________________________

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

   Hours per day:

   Sun ___________ Mon ___________ Tues ___________ Wed ___________ Thu ___________ Fri ___________ Sat ___________

   or if your schedule is more than 21 days, attach a copy of the schedule.
What happens when your worker is injured at work?

1. **Employer**
   - Your worker immediately informs you. You complete and send a form to WCB within 72 hours.

2. **Doctor**
   - Your worker sees a doctor about the injury. The doctor completes and sends a form to WCB within 48 hours of your worker’s visit.

3. **Worker**
   - Your worker completes a Worker Report of Injury or Occupational Disease form and sends it to WCB as soon as possible.

WCB registers your worker’s claim and assigns it to a staff member.

- If more information is required to make a decision or if some is missing, WCB will contact you, your worker, or their doctor. *This causes delays in payment.*

**Claim not accepted**

- The legislative and policy requirements were not met by the information collected. Your worker will be advised of the reason by phone and in writing. They have the option to appeal within one year.

**Claim accepted**

- The legislative and policy requirements were met. Benefits and services may include:
  - Wage loss replacement
  - Medical costs
  - Case management services
  - Return-to-work assistance

- Your worker has not missed work past the day of injury, a claim process team will monitor their medical treatment.
- Teams also review letters and reports for evidence a claim may require adjudication.

- WCB assigns your worker’s claim to an adjudicator who makes the initial benefit decisions.
- If your worker needs additional rehabilitation support to return to work, the claim may be transferred from an adjudicator to a case manager.

Any questions?

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