Workers' Compensation Board – Alberta
Box 2415
Edmonton AB, T5J 2S5
Fax: 780-427-5863 or 1-800-661-1993
contact.centre@wcb.ab.ca

C1138
SHORT-TERM HOME ASSISTANCE INVOICE

Please print clearly

WORKER DETAILS

Worker's Surname	First Name	Initial	WCB Claim Number
			Date of Birth (YYYY/MM/DD)
Address Street			Date of Accident (YYYY/MM/DD)
City / Town		Province	Postal Code

Date of Service *(YYYY/MM/DD)*	Description of Service	Hourly Rate	Hours Billed	Total Cost
			TOTAL	$ 0.00

Did you pay for the service? ☐ Yes ☐ No

Please complete the name and address section below with who provided the service.

Name and address of who provided service (please print)	Provider's Signature	Date (YYYY/MM/DD)
	Provider's Name (please print)	
	FEE CODE SSF08	Telephone Number
		Email Address

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.