Injury Report Instructions

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

**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.
# Worker Report of Injury or Occupational Disease

**C060**

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**Employer Details**

- Employer business name: [Insert employer name]
- Mailing address: [Insert mailing address]
- City: [Insert city]
- Province: [Insert province]
- Postal code: [Insert postal code]
- Contact name: [Insert contact name]
- Title: [Insert title]
- Phone: [Insert phone number]
- E-mail: [Insert e-mail]

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**Worker Details**

- Last name: [Insert last name]
- First name: [Insert first name]
- Initial: [Insert initial]
- Mailing address: Apt# [Insert apartment number]
- Social Insurance #: [Insert social insurance number]
- City: [Insert city]
- Province: [Insert province]
- Postal code: [Insert postal code]
- Contact name: [Insert contact name]
- Title: [Insert title]
- Phone: [Insert phone number]
- E-mail: [Insert e-mail]
- Contact name: [Insert contact name]
- Title: [Insert title]
- Phone: [Insert phone number]
- E-mail: [Insert e-mail]

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**Accident Details**

- Date/time of accident: [Insert date and time]
- Time: [Insert time]
- a.m. or p.m. or the injury/condition developed over time
- Date/time scheduled shift started (if applicable): [Insert date and time]
- Time: [Insert time]
- a.m. or p.m.
- Date/time scheduled shift ended (if applicable): [Insert date and time]
- Time: [Insert time]
- a.m. or p.m.
- Date accident/injury reported to employer: [Insert date]
- Name of person and their position: [Insert name and position]
- Phone number: [Insert phone number]

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**Description**

Provide a detailed description of what happened, including any tools, equipment, materials, etc. you were using. State any gas, chemicals or extreme temperatures you may have been exposed to.

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Cardiac condition/injury? [ ]
Claimed to another WCB? [ ] Province: [Insert province]
Motor vehicle accident? [ ] If you have a police collision report, please send a copy by mail or fax once you have a claim number. Please also complete the WCB Automobile Accident Report.

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

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

Were 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

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

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Full name of treating hospital or healthcare professional:
- Address: [Insert address]
- Phone: [Insert phone number]

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When did you first seek medical treatment? [Insert date]
Is any further treatment required? [ ] Yes [ ] No

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Complete all three pages and sign the form before sending.

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

Return-to-Work Details
Please complete all the information that applies.

Employment Type 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.

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.

For information about WCB-Alberta benefits and services, please have a look at our Worker Handbook. It explains what you can expect during your claim and may answer some of the questions you have.
### Worker Report

**Worker's last name:** __________________________
**Worker's first name:** __________________________
**Initial:** __________________________

**Social Insurance #:** __________________________
**Date of birth:** __________________________

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#### 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.)

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#### Return to Work Details

- [ ] I understand I have a duty to cooperate with WCB in arranging my safe and healthy return to work with my employer.

7. Will/did your employer pay you while off work?
- [ ] Yes, pre-accident wages
- [ ] Yes, revised rate of pay
- [ ] No
- [ ] Unknown

Revised rate of pay: $ __________ per ________

- [ ] Yes
- [ ] No

If you have returned to work indicate date: __________________________

If you are working modified duties please describe:

Approximate date you expect to return to work: __________________________

- [ ] Within 2 weeks
- [ ] 2-8 weeks
- [ ] 2-6 months
- [ ] 6+ months
- [ ] Unknown

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#### Employment Type Details

8. 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: __________________________
- [ ] Position end: __________________________

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.

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#### Earning Details

a. Your rate of pay at time of accident: __________ per ________

b. Additional taxable benefits:

- [ ] Vacation pay: __________
- [ ] Taken as time off with pay
- [ ] Paid on a regular basis % __________

Shift premium
- [ ] Overtime
- [ ] Other

Please describe:

- [ ] 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.

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Complete all three pages and sign the form before sending.
If your injury was sustained in an automobile accident, fill out and send an Automobile Accident Report along with the Worker Report.