# Employer's Report

## of Injury or Occupational Disease

JANUARY 2013



## *Important Information*

### 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's 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

WCB Workers' Compensation Board Alberta

# Employer's 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 the first page only of the form.)

## Worker Information

Please provide as much information as possible.

## Employer Information

**2 Employer contact**

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

## Injury or Occupational Disease Information

**3 Date & time of injury**

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

**4 When was someone notified of the injury?**

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

**5 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.

**6 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.*

**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.

**7 Physical Demands of the job**

**Sedentary**
- Lifting 10 lbs maximum
- Occasional lifting/carrying
- Primarily sitting, with occasional walking/standing

**Light**
- Lifting 20 lbs maximum
- Frequent lifting/carrying up to 10 lbs
- May require walking/standing to a significant degree
- May involve sitting with pushing and pulling of arm and or leg controls

**Medium**
- Lifting 50 lbs maximum
- Frequent lifting/carrying up to 20 lbs
- May involve sitting with pushing and pulling of arm and/or leg controls

**Heavy**
- Lifting 100 lbs maximum
- Frequent lifting/carrying up to 50 lbs

**Very Heavy**
- Occasional lifting in excess of 100 lbs
- Frequent lifting/carrying excess of 50 lbs

*Reference: The Canadian Classification and Dictionary of Occupations*

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.

## Time Lost/Return to Work Information

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

## Type of Employment

**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 him/her 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 a contractor, subcontractor, or does piece work.

## Wage Information

**10 b. 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).

**11 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, 2012. Provide gross earnings for the period June 4, 2011 to June 3, 2012. 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. 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

**12 a. Number of Hours**
Indicate the regular hours of work, not including overtime periods.

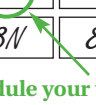
**b. Does work schedule repeat?**
***If No:*** Report the average number of regular hours worked per week during the year prior to the injury. Do NOT complete the work schedule.

***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 | Thurs | 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.**

Workers' Compensation Board
Alberta

P.O. BOX 2415
EDMONTON AB T5J 2S5

University of Calgary - STUDENT

**Phone 780-498-3999** (in Edmonton)
**1-866-922-9221** (toll free in Alberta
**Fax: 780-427-5863 (Edmonton)**
**or 1-800-661-1993 (within Canada)**

January 2013

# EMPLOYER'S REPORT
## of Injury or Occupational Disease C040

Seven Digit Claim #:
(if available)

**Claim Type**

1 ☐ **Time Lost** ☐ **Modified Work** ☐ **Fatality**
Complete entire report if claim type is one of the above

☐ **No Time Lost (Notice of non-disabling injury/illness)**
Complete first page only

## Worker Information

Last Name: | Former Name: (e.g., maiden name) | First Name: | Initial:

Address: | Apt #: | Social Insurance #:

City: | Province: | Postal Code: | Health Care #: - | Province:

Daytime Phone: | Evening Phone: | Date of Birth: (Year / Month / Day) | Sex: ☐ M ☐ F

Occupation: | Apprentice: ☐ Yes ☐ No

## Employer Information

Business Name or Government Department:
Alberta Post Secondary Learning

WCB Account Number: 3161508 | Industry: 8 0 5 0 0

Does the injured worker have WCB personal coverage with this business? ☐ Yes ☐ No

Mailing Address: 10020 - 101A Avenue

Is injured worker a proprietor, partner or director in this business? ☐ Yes ☐ No

City: Edmonton

2 Employer/Supervisor Contact Name:

Province: Alberta | Postal Code: T5J 3G2

Phone:

Phone: 780-427-6897 | Fax:

E-mail Address:

## Injury or Occupational Disease information

3 Date and time of injury: (Year / Month / Day) | Time: ☐ a.m. ☐ p.m. ☐ This condition developed over a period of time.

Scheduled hours of employment on the day of accident: From: To:

4 When was someone at your business notified of the injury? (Year / Month / Day) | Time: ☐ a.m. ☐ p.m.

Name of person and their position: | Contact Information:

Did the injury occur on employer's premises? ☐ Yes ☐ No | Did injury occur in Alberta? ☐ Yes ☐ No

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

6 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:

If you have more information, please attach a letter. Letter attached? ☐ Yes ☐ No

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

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

Were the worker's actions at the time of injury for the purpose of your business? ☐ Yes ☐ No

Were the actions part of the worker's regular duties? ☐ Yes ☐ No

7 Check the box that best describes the physical demands of the regular duties: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy
( See detailed description on page 2 of attached instructions)

Indicate type of aid provided: ☐ First aid ☐ Medical aid (Name of treating healthcare professional/hospital): _____ ☐ None

Was a copy of this report given to the injured worker as per the *Workers' Compensation Act?* ☐ Yes ☐ No ☐ Worker declined it

(for office use only)

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.***

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

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

## 8 Lost Time/Return to Work Information

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

b. Will/did you pay the worker while off work? ☐ Yes ☐ No

If yes, will/did you pay: ☐ Pre-accident rate of pay and hours of work | Rate: $_____ per_____, *or* Number of hours:___ per_____, *or* gross amount: $_____

For the period from: (Year / Month / Day) to ( Year / Month / Day)

c. If the worker has returned to work indicate date: (Year / Month / Day) Time: ☐ a.m. ☐ p.m.

Check: ☐ 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 _____

d. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? ☐ Yes ☐ No ☐ Was offered but the worker declined

## 9 Type of Employment (Complete A or B or C)

**A** ☐ Permanent position employed 12 months of the year: ☐ Full-time ☐ Part-time

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

☐ Seasonal worker ☐ Temporary position ☐ Casual as needed ☐ Volunteer ☐ Summer student

Had this injury not occurred the worker's last day of employment would have been: (Year / Month / Day) ☐ Estimated *or* ☐ Actual

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

*or* **C** Special employment circumstance: ☐ Contractor/sub contractor ☐ Vehicle owner/operator ☐ Welder owner/operator ☐ Commission

☐ Piece work ☐ Other/self-employed

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

## Wage Information

Date the worker was hired: (Year / Month / Day)

a. Worker's rate of pay at time of accident: $ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other:

**10** b. Additional taxable benefits:

| | | | | | |
|---|---|---|---|---|---|
| Vacation Pay | ☐ Taken as time off with pay | %: | | OR | ☐ Paid on a regular basis |
| Stat Holiday Pay | ☐ Included in rate of pay | %: | | OR | ☐ Taken as time off with pay |
| Shift Premium | Gross earnings: $ | | from: (Year / Month / Day) | to | (Year / Month / Day) |
| Overtime | ☐ Rate: $ | ➔ Number of hours: | per ☐ Week ☐ Month ☐ Year ☐ Shift cycle | | |
| Other | ☐ Explain: | ➔ Amount: | per ☐ Week ☐ Month ☐ Year ☐ Shift cycle | | |

**11** a. Gross earnings for the period of one year or date the worker was hired if less than one year: $ from: (Year / Month / Day) **(12 months or less prior)** to: (Year / Month / Day) **(date of injury)**

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

If yes, number of days: Reason:

## Hours of Work

**12** a. Number of hours (not including overtime): per ☐ Day ☐ Week ☐ Shift cycle ☐ Other:

b. Does the work schedule repeat? ☐ No ☐ Yes ➔ Mark hours worked for one complete work schedule (use zero for days off):

Average hours worked per week:

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

| | Sun | Mon | Tues | Wed | Thur | Fri | Sat |
|---|---|---|---|---|---|---|---|
| Hours per day: | | | | | | | |
| Hours per day: | | | | | | | |
| Hours per day: | | | | | | | |

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

***or*** If the worker's schedule is more than 21 days, attach a copy of schedule.

Earnings Information Contact (please print): Phone Number:

# *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's Report of Injury or Occupational Disease* form and sends it to WCB as soon as possible.

Employer's Report

Doctor's Report

Worker's Report

## 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.

## Appeal

## 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

### Time lost claims

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**.

### No time lost claims

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.

## Any questions?

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

WCB Workers' Compensation Board
Alberta

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