

Employer Report

of Injury

SEPTEMBER 2014

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 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



Workers'
Compensation
Board

Alberta

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.

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.

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.

9 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

10 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

Phone 780-498-3999 (in Edmonton)
1-866-922-9221 (toll free in Alberta)
1-800-661-9608 (outside Alberta)

Fax 780-427-5863 or 1-800-661-1993

September 2014

EMPLOYER REPORT of Injury

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 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: ☐ M ☐ F
Occupation:		Job description:		Date hired: _____ (Year / Month / Day)	
Does the worker have WCB personal coverage with this business? ☐ Yes ☐ No Is the worker a partner or director in this business? ☐ Yes ☐ No					
Is the worker an apprentice? ☐ Yes ☐ 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:		2 Employer/Supervisor Contact Name and Title:			
City:					
Province:	Postal Code:	Contact Phone: _____			
Phone:	Fax:	Contact E-mail: _____			

Accident Details

3	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.	
4	Date accident/injury reported to employer: _____ (Year / Month / Day)		
To whom was the accident/injury reported?:		Phone Number: _____	
5	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: _____ _____ _____		
Motor vehicle accident? ☐ Yes ☐ No Cardiac condition/injury? ☐ Yes ☐ No		Letter attached? ☐ Yes ☐ No	
Did the accident/injury occur on employer's premises? ☐ Yes ☐ No			
6	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? ☐ Yes ☐ No			
Were the actions part of the worker's regular duties? ☐ Yes ☐ No			

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)



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.

Worker's Last Name:	Worker's First Name:	Initial:
Social Insurance #:	Date of Birth: (Year / Month / Day)	

7 Return to Work Details

a. Will/did you pay the worker regular pay while off work? ☐ Yes ☐ No		Has the worker returned to work? ☐ Yes ☐ No	
b. Date and time worker first missed work: (Year / Month / Day)		Time: ____ : ____ ☐ a.m. ☐ p.m.	
c. If the worker has returned to work, indicate date: (Year / Month / Day)		Time: ____ : ____ ☐ a.m. ☐ p.m.	
Current work status: ☐ 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 ____			
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 ☐ Was offered but the worker declined			
e. Approximate return to work date: (Year / Month / Day)		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: (Year / Month / Day)		Position end date: (Year / Month / Day) ☐ Estimated ☐ Actual	
How many months or days per year do you employ workers in this position?			
or C Alternate employment: ☐ 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

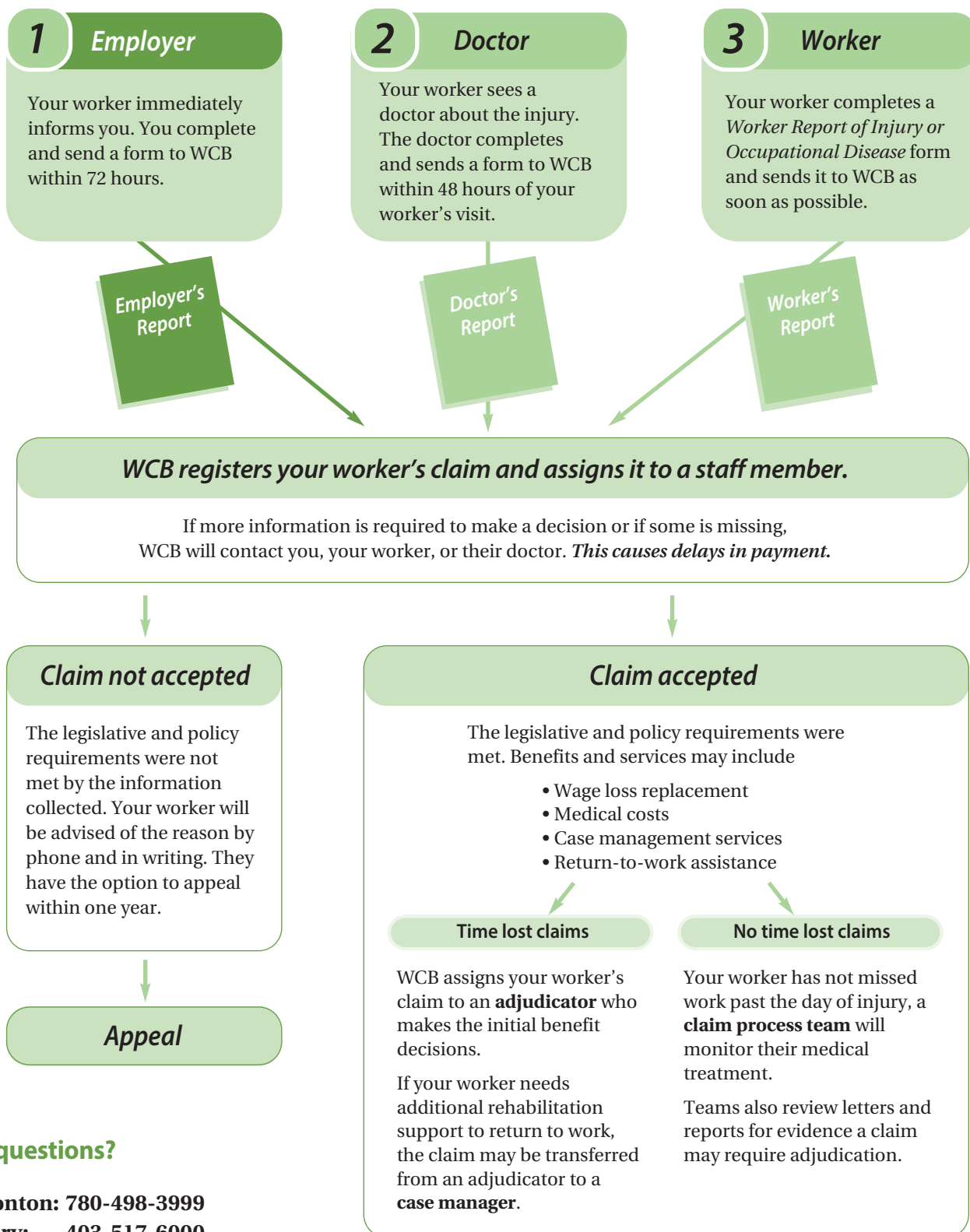
Earnings information contact name (please print):	
Earnings contact phone number:	Earnings contact e-mail:
Choose A or B:	
A Gross earnings for the period of one year prior to the date of injury or date the worker was hired if less than one year: \$ ____ from: (Year / Month / Day) to: (Year / Month / Day)	
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: (Year / Month / Day) to: (Year / Month / Day)
Overtime Gross earnings: \$ ____	from: (Year / Month / Day) to: (Year / Month / Day)
Other Gross earnings: \$ ____	from: (Year / Month / Day) to: (Year / Month / Day)

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: (Year / Month / Day) <table border="1" style="width:100%; text-align: center;"> <tr> <th>Sun</th><th>Mon</th><th>Tues</th><th>Wed</th><th>Thur</th><th>Fri</th><th>Sat</th></tr> <tr> <td>Hours per day: ____</td><td>____</td><td>____</td><td>____</td><td>____</td><td>____</td><td>____</td></tr> <tr> <td>Hours per day: ____</td><td>____</td><td>____</td><td>____</td><td>____</td><td>____</td><td>____</td></tr> <tr> <td>Hours per day: ____</td><td>____</td><td>____</td><td>____</td><td>____</td><td>____</td><td>____</td></tr> </table>	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Hours per day: ____	____	____	____	____	____	____	Hours per day: ____	____	____	____	____	____	____	Hours per day: ____	____	____	____	____	____	____
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Mark hours worked for one complete work schedule (use zero for days off): or if your schedule is more than 21 days, attach a copy of the schedule.																													
IMPORTANT Circle day of injury. See instructions																													



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



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