Alberta Workers' Health Centre
Work Plays Schools Program
Resource Package

Injured at Work?

You have the right to report a work-related injury or illness to the Workers' Compensation Board (WCB).

Workers Compensation Board (WCB)
1-866-922-9221
www.wcb.ab.ca/workers

You have the right to a safe, healthy and fair workplace.
We can help.

www.workershealthcentre.ca

If you are injured at work...

Tell Your Employer

details of your injury

After receiving notice, your employer must report your injury to WCB within 72 hours if:

- you need medical treatment beyond first aid, or
- you cannot do your job beyond the day of accident.

Tell Your Health Care Provider

you were injured at work

Your doctor or Chiropractor must report your injury to WCB within 48 hours.

Tell WCB

Send your Report of Injury form to WCB right away!

You can get forms from your employer, any WCB office or report online at **www.wcb.ab.ca.**

Avoid delays. Report early!

Send forms:
By mail: PO Box 2415, Edmonton, AB T5J 2S5
By fax: Edmonton 780-427-5863
or Toll-Free 1-800-661-1993

For more information call:
Edmonton: 780-498-3999 or Toll-Free 1-866-922-9221

Website: www.wcb.ab.ca

WCB Workers' Compensation Board Alberta

Note: Employers are required under the Workers' Compensation Act, Section 145, to hang this poster in a place where employees can see it.

G-083 REV MAY 2008

Claims process

Filing a claim

Once you have submitted your report of injury to WCB-Alberta, you have filed a claim. You can expect to hear from WCB-Alberta in regards to your claim within seven days of submitting your report. You can update your claim information at any time by contacting WCB-Alberta.

What happens with your claim

WCB-Alberta will review the injury information provided by you, your employer and your healthcare provider. WCB-Alberta will use this information to determine if the *Workers' Compensation Act* applies to you and if you are eligible for compensation benefits.

If your claim is accepted

WCB-Alberta will work with you and your employer to help you return to work safely. Your case manager will coordinate rehabilitation services and wage replacement payments. For more information on benefits and payments, see the Determining compensation rates fact sheet.

If your claim is denied

If your claim does not meet policy and legislation requirements for coverage, your claim will be denied. You may submit more information at this time. Your case manager will review all your input and if the decision remains the same, you have one year to request an internal review. If after a formal, internal review the decision remains unchanged, you may appeal to an external review body (also within one year). For more details, see the Questioning a WCB-Alberta decision fact sheet.

Return to Work

Speak to your employer about return to work options like modified work. Wage replacement benefits last while you are totally disabled from all forms or work. Once you are medically able to return to employment (even if it is not exactly what you were doing when you were injured), wage replacement benefits stop. Depending on your circumstances, re-employment benefits may be available for a limited time.

Talk to your case manager

If you have questions or are unsure of the claims process, your case manager can help. Call him or her regularly to discuss your progress.

Representatives

You do not need to find or hire a representative to help you with your claim. However, if you want to have the assistance of a friend, family member or advocate, you must complete a form to Authorize a Worker Representative and to notify WCB-Alberta who your representative will be. You can download the form from our website at http://www.wcb.ab.ca/pdfs/workers/C622.pdf or contact a Claims Contact Centre representative.

Translation

If you need help communicating with WCB-Alberta in English, inform your case manager. WCB-Alberta can hire a translator to help make sure that everyone is completely understood.

Website: **www.wcb.ab.ca**
Toll-free: 1-866-922-9221 (within AB)
Edmonton Ph: 780-498-3999
Calgary: Ph: 403-517-6000

E-mail: **contactcentre@wcb.ab.ca**
1-800-661-9608 (outside AB)
Fax: 780-498-7999
Fax: 403-517-6201

Box 2415, 9912-107 Street
Edmonton, AB T5J 2S5

Workers' Compensation Board
Alberta

Your rights with a claim

Fairness and impartiality	Fair and impartial determination on any issue arising from the WC Act.
The presumption of honesty	You are presumed honest unless proven otherwise.
Privacy and confidentiality	Any information given to WCB-Alberta will be used only for the purposes of the claim within the WC Act.
Courtesy and consideration	You will receive courteous and considerate treatment from all WCB-Alberta staff.

Who is involved in your claim

You	It is important for you to be actively involved in your return-to-work planning.
Your employer	Talk to your employer about modified work. Your employer has access to your claim information.
Your healthcare providers	Regular reporting of your progress with your injury/illness is needed on your claim.
Your adjudicator or case manager	This is your primary source of information. Case managers and adjudicators are trained to apply the Workers' Compensation Act and are committed to helping you return to work.

You can reference the *Workers' Compensation Act* at:
http://www.wcb.ab.ca/public/policy/legislation.asp

Injury Report Instructions

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

Worker Information

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 Information

2 Please complete all the information.

Injury or Occupational Disease Information

3 Date and time of injury

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 When was someone notified of your injury?

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 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. Check the appropriate box at the right to indicate whether the injury happened in Alberta.

6 Physical Demands

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

Light
- Lifting 20 lbs maximum
- Frequent lifting and/or carrying up to 10 lbs
- May require significant walking/standing
- 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

7 Type of injury

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.

8 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.

Workers' Compensation Board
Alberta

PO BOX 2415
EDMONTON AB T5J 2S5
Phone: 780-498-3999 (in Edmonton)
1-866-922-9221 (toll free in Alberta)
Fax: 780-427-5863 or 1-800-661-1993

January 2011

WORKER'S REPORT
of Injury or Occupational Disease C060

Seven Digit Claim #:

Worker Information

Past the day of injury: Have you been off work? ☐ Yes ☐ No

1 Have your work duties been modified? ☐ Yes ☐ No

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 and job title at time of injury: | Self employed? ☐ Yes ☐ No → If yes, WCB-Alberta account #:

E-mail address: | Apprentice? ☐ Yes ☐ No

Employer Information

2 Business Name or Government Department:

Mailing Address: | Fax:

City: | Province: | Postal Code: | Phone:

Injury or Occupational Disease Information

3 Date and time of injury: (Year / Month / Day) Time: ☐ a.m. ☐ p.m. **or** ☐ 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 place of employment notified of your injury? (Year / Month / Day) Time: ☐ a.m. ☐ p.m.

Name of person and their position: | Phone:

If not reported immediately, give the reason:

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

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

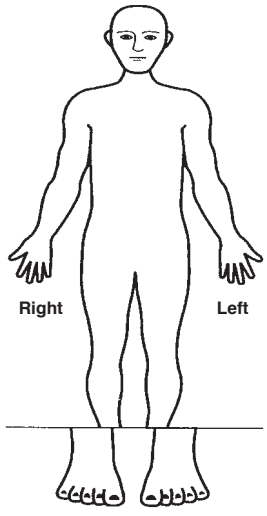
Was the work you were doing for the purpose of your employer's business? ☐ Yes ☐ No If yes, was it part of your usual work? ☐ Yes ☐ No

6 Please check the box that best describes the physical demands of your work: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy
(see detailed description on page 22 of the Worker Handbook)

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

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

Circle part injured
Please check: ☐ Front ☐ Back



8 Describe fully what happened to cause this injury or disease. Describe what you were doing and include any tools, equipment, materials, etc. you were using. State any gas, chemicals or extreme temperatures you have been exposed to:

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

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

Have you reported or claimed this injury to another WCB? ☐ Yes ☐ No If yes, which province or territory?

Full name of treating hospital or healthcare professional:

Address:

Phone: | Date of first medical treatment: (Year / Month / Day)

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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 Motor Vehicle Accident Report (L-054).

Please fill in your name, Social Insurance Number and date of birth at the top of each page of the form in case the pages get separated.

Remember to complete all three pages and sign the form before sending.

Time Lost / Return-to-Work Information

9 Please complete all the information that applies.

Type of Employment

10 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.

Wage Information

11 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 (therefore must take these days off without pay) or, these days are included as days off with pay.

Shift premiums
Complete if you get paid in addition to your regular rate of pay (e.g., 50¢ paid per hour for night shift). If you get more than one shift premium (e.g., night premium, weekend premium), complete both shift premium boxes. Attach a list if you have three or more shift premiums.

Regular overtime
Complete only if you work the same number of hours overtime each week, month or shift cycle.

c) 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

12 a) Number of hours

Indicate your regular hours of work.
Do not include overtime here.

b) Does your work schedule repeat?

If no:

Report the average number of hours worked per week during the year prior to the injury. Do NOT complete the work schedule.

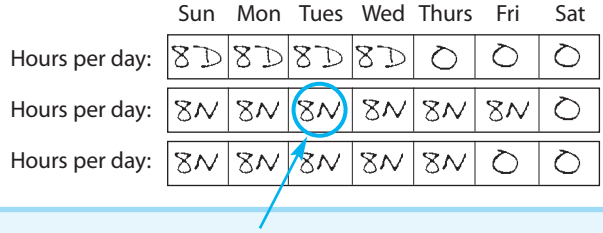
If yes:

Mark the number of hours you worked per day in each of the boxes. Put zero for days off. Please 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 you were injured to determine the compensation to pay you. Circle the day on this work schedule that you were injured. *See example below.*

Or:

If you have a work schedule **longer than 21 calendar days**, attach a copy of your schedule or describe your work schedule on a separate piece of paper. Circle the day on this work schedule that you were injured.

***Example:** You worked eight-hour days in the first week and eight-hour nights in the second and third weeks. You were injured on the Wednesday of the second week and were off work for two days (Thursday and Friday). You would be paid WCB-Alberta benefits for two days.*



***Important:** Circle the day in the work schedule you were injured.*

D = day • N = night • O = off

Your Last Name: First Name: Initial:

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

Time Lost / Return to Work Information

PLEASE COMPLETE ALL THAT APPLY

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

b. Will/did your employer pay you while off work? ☐ No ☐ Yes, pre-accident wages ☐ Yes, but revised rate: $_____ per _____

c. Is there any other work you can do until you are medically fit to return to your regular job? ☐ Yes ☐ No

If yes, who can we call to discuss alternate work on your behalf? Phone:

d. If you have not returned to work give the expected return to work date: (Year / Month / Day)

e. If you have returned to work, indicate the date: (Year / Month / Day) Time _____ ☐ a.m. ☐ p.m. ☐ Regular work, or ☐ Modified work

f. If back on modified work, are you: Being paid your pre-accident rate of pay? ☐ Yes ☐ No – provide rate: $_____ per_____

Working pre-accident hours? ☐ Yes ☐ No – provide hours: _____ per_____

Type of Employment

(Complete A or B or C)

10 A Permanent position employed 12 months of the year: ☐ Permanent full-time ☐ Permanent 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 ☐ Summer student ☐ Volunteer

Had this injury not occurred, your last day of employment would have been: (Year / Month / Day) ☐ Estimated or ☐ Actual

Did you have any other earnings, or income from any other employers, during the last 12 months? ☐ Yes - Please attach copies of pay stubs and/or T4 slips

or **C** Special employment circumstance:

☐ Contractor/sub contractor ☐ Vehicle owner/operator ☐ Welder owner/operator ☐ Commission ☐ Piece work ☐ Other/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 12C please submit a detailed income and expense statement.

Wage Information

Date you were hired: (Year / Month / Day)

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

b. Additional taxable benefits:

Vacation Pay	☐ Included in rate of pay	%:	OR	☐ Taken as time off with pay	
Stat Holiday Pay	☐ Included in rate of pay	%:	OR	☐ Taken as time off with pay	
Shift Premium #1	☐ Amount: $	→	Paid per:		
Shift Premium #2	☐ Amount: $	→	Paid per:		
Regular Overtime	☐ Rate: $	→	Number of hours:	per ☐ Week ☐ Month	☐ Shift cycle
Other	☐ Explain:	→	Amount:	per ☐ Week ☐ Month	☐ Shift cycle

c. Do you have a second job? ☐ Yes ☐ No If yes – Employer's Name: Phone:

(Second employer may be contacted.)

d. Did you miss time from this second job? ☐ Yes ☐ No If yes, please attach earning information and time missed details.

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:

	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 your schedule is more than 21 days, attach a copy of the schedule.

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

C 0 6 0 REV JAN 2011

Complete all three pages and sign the form before sending.

Your Last Name:	First Name:	Initial:
Social Insurance #:	Date of Birth: (Year / Month / Day)	Phone:

Declaration and Consent

I declare that the information in the *Worker's Report of Injury or Occupational Disease* form will be true and correct.

I understand that:

- While I am receiving any benefits from WCB-Alberta, it is my obligation to inform WCB-Alberta immediately if I return to work of any kind, become capable of working or if there is any other change in my employment status. Work includes but is not limited to any activity in which labour or services are provided, whether or not payment of any kind is received.
- Criminal prosecution may result from any attempt on my part to collect benefits by providing false information, failing to provide information regarding my ability to work, or other fraudulent means.
- My employer may request a review or appeal of any decisions made on my claim and may therefore examine my claim file. My claim file may also be examined by anyone with a direct interest, as determined by WCB-Alberta, or a person or company I have authorized to review my claim file. (To provide authorization, use the *Worker's Information Release* form in this booklet).
- My social insurance number may be used for reporting to Canada Revenue Agency.
- WCB-Alberta may collect information that it considers relevant to determine benefit entitlement, including information pre-dating my accident, from any source including physicians, other health care providers, employer(s) and vocational rehabilitation service providers. This information is collected to determine my entitlement to compensation under the *Workers' Compensation Act*.

WCB-Alberta may use and disclose the information collected to determine entitlement, to provide services and benefits and, as required or authorized by law. This information may be used and disclosed pursuant to the *Workers' Compensation Act* and the *Freedom of Information and Protection of Privacy Act.*

(Year / Month / Day)

Date: _____ Name (please print): _____

Signature: _____

Signing the above consent enables the Workers' Compensation Board to process your claim.

NOTE: The information required in the *Worker's Report of Injury or Occupational Disease* is collected under sections 33(a) and (c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of determining entitlement to compensation and for determining employers' premium rates. Questions may be directed to the Claims Contact Centre as noted on the front of this form and on the back of the Worker Handbook. The information provided to the Workers' Compensation Board is protected by the provisions of the *Freedom of Information and Protection of Privacy Act.*

This report form is part of a booklet of information intended to help workers with completing the necessary WCB-Alberta forms and understanding the process. Keep the booklet for your reference.