Student injured on the job?

HERE'S WHAT TO DO!

2015-16 Handbook for Student Employers
OFF-CAMPUS EDUCATION
Crescent Heights High School
**Procedure:**
In case of injury to a student while working as part of an Off-Campus Education Program such as:
- Work Experience
- Registered Apprenticeship (RAP)
- Production Field Operator Internship (PFO)
- Health Services Placement
- Green Certificate

**1st Step- Immediately Contact:**

#1 Off-Campus Education Coordinator, Kelly Roach
- School Phone: 403-527-6641 ext 8295
- Cell Phone 403-504-7890
- Home Phone 403-504-5110
- School Fax: 403-528-6578

If for some reason you cannot contact Mr. Roach

Contact one of the following CHHS staff:
- #2 VP: Mr. Hank Joly at Cell 403-866-6739
- #3 VP: Mr. Dean Brown at Cell 403-502-3992
- #4 Principal: Mr. Pat Grisonich at Cell 403-548-9694

WCB reports are very time sensitive and must be sent in within 72 hours. Remember that the student is covered under WCB through Alberta Education and not your company’s WCB policy.

Follow the Procedure sheet on the following page. Copies of the Worker and Employer WCB forms and the WCB student worker Fact Sheet are also supplied with this package.

Please note* if you use your own copies of the forms to insert the Words “Alberta Education” beside “Employer” and your normal Employer name and address info after that. Make Sure you use the Alberta Education Account number (345912/6) as given on the Sample forms and NOT your own.
SAMPLE 8.1 – MODEL OF INJURY REPORTING PROCEDURE

Injury to the Student

- Student reports injury to Employer and School’s Off-Campus Coordinator
- Medical treatment provided
- Parent contacted

Student completes Worker’s Report of Injury or Occupational Disease Form available online at http://www.wcb.ab.ca/pdfs/workers/c060.pdf

Employer completes Employer’s Report or Injury or Occupations Disease Form (does not insert any account number) available online at http://www.wcb.ab.ca/pdfs/c040.pdf

Reports given immediately to the School’s Off-Campus Coordinator

School-Based Off-Campus Coordinator (Mr. Roach):

- checks accuracy of reports
- inserts Alberta Education’s account code 345912/6 and signs name plus writes “on behalf of Alberta Education”
- faxes both completed forms within 72 hours of incident to
  - Curriculum Sector at 1-780-422-3745
    Attention: Director, Curriculum Branch
    and faxes
  - Workers’ Compensation Board at 1-780-427-5863
- maintains original copies of forms
- consults with employer on how to prevent similar incidents from occurring in the future
Student Coverage

Students registered in a secondary school are considered workers of the Government of Alberta while they are attending and participating in a work-experience program or the practical experience part of a work-related program, including courses in Industrial Education and Home Economics (i.e. Career and Technology Studies), if the program has been designated as such by the secondary school and approved by the Workers’ Compensation Board.

Students registered in and attending a post secondary institution, as outlined in section 7 of the General Regulations to the Alberta Workers’ Compensation Act, who are enrolled in a vocational or academic program which is a current academic requisite or required as part of the course of study in which the student is registered, are considered workers of the Government of Alberta. This coverage also extends to students placed with Alberta employers to gain practical knowledge related to their studies.

In both cases, students will be provided workers’ compensation coverage under the Government of Alberta’s account, pursuant to a Board Order issued in accordance with Section 7(1) of the General Regulations to the Alberta Workers’ Compensation Act.

* WCB-Alberta will not extend coverage to students who are participating in a “Take Your Child to Work” Program.

Student work experience outside Alberta

If Alberta-based students are sent outside of Alberta for their practical work, the work experience employer must contact the workers’ compensation agency of the jurisdiction they will be working in to determine the coverage requirements.

WCB-Alberta may extend coverage to students working outside of Alberta if all the conditions of Section 28(1) of the Alberta Workers’ Compensation Act are met.

Each case involving a student doing practical work outside Alberta will be reviewed on its own merits. Before the student leaves, an employer should contact WCB-Alberta to discuss the situation.

Apprentices

WCB-Alberta Policy 06-01 Part II, Application 3, refers to apprentice coverage. Apprentices working in Alberta are covered as workers of their sponsoring employers, if they have one. This includes coverage while attending classes prescribed by the Apprenticeship and Industry Training Board. If there is no sponsoring employer, an apprentice is considered a worker of the Government of Alberta.

My worker is injured…what do I do?

Employers have a number of responsibilities they must adhere to under the Workers’ Compensation and Occupational Health and Safety Acts when a work-related injury/illness occurs. Meeting these responsibilities and managing return to work enables injured workers to safely return to work at the earliest opportunity, thus reducing claim costs.

Responsibilities:

Provide first aid
Provide immediate first aid in accordance with Occupational Health and Safety (OHS) legislation.

* Helpful Link: OHS - First Aiders & Legal Requirements

Provide transportation to medical treatment
Provide and pay the cost of transport from the injury site to a medical treatment facility, if needed.

Keep a record
Record details of the injury/illness, even if first aid is not administered, and give a copy to the worker. Records must be kept confidential and for a minimum of three years. You must record:
- name of the worker
- date and time of the injury/illness
- date and time it was reported to you
- description of the injury/illness, where it occurred and the cause
- first aid provided
- name and qualifications of the person giving first aid

* Helpful Link: OHS - First Aid Record

Report to WCB-Alberta/OHS
Report to WCB-Alberta within 72 hours of being notified of an injury/illness that results in or will likely result in:
- lost time or the need to temporarily or permanently modify work beyond the date of accident
- death or permanent disability (amputation, hearing loss, etc.)
- a disabling or potentially disabling condition caused by occupational exposure or activity (poisoning, infection, respiratory disease, dermatitis, etc.)
- the need for medical treatment beyond first aid (assessment by a physician or chiropractor, physiotherapy, etc.)
- medical aid expenses (dental treatment, eyeglass repair/replacement, prescription medications, etc.)

You do not have to report injuries such as cuts, scrapes, scratches, minor burns or removing splinters that only require first aid by a first aid provider.

Note: Immediately report fatalities and serious injuries to the OHS Contact Centre at 1-866-415-8690.

* Helpful Links:


OHS - Report an Incident  OHS - Serious Injuries

Pay full wages for the date of accident
You are required to pay injured workers the full wages they would have received if not injured, and you cannot deduct those wages from their sick pay or other entitlement.

Advise WCB-Alberta of return to work
Notify WCB-Alberta within 24 hours of the return to work following lost time beyond the date of accident.
Manage return to work:
Work with your injured worker, health care provider and WCB-Alberta to arrange return to work at the earliest opportunity by providing suitable modified work.

Obtain fitness for work information immediately following initial treatment
Have an information package ready for injured workers requiring medical treatment including:
- a notice to the injured worker indicating what is expected, including attending treatments, regularly advising you of fitness status and cooperating in return-to-work planning
- a fitness for work form with notice to health care provider and medical release authorization
- a list of available modified work duties and physical demands analysis of the worker’s job duties to assist in determining fitness for work
- a WCB-Alberta Worker Handbook (optional)

Consider using an Occupational Injury Service (OIS) that provides timely and appropriate medical care and disability management services specifically for work-related injuries.

*Helpful Links:

<table>
<thead>
<tr>
<th>Notice to Injured Worker</th>
<th>Fitness for Work Form</th>
<th>Physical Demands Analysis Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCB - Worker Handbook</td>
<td>WCB - OIS Information</td>
<td></td>
</tr>
</tbody>
</table>

Arrange modified work at the earliest opportunity
Offer suitable modified work in keeping with work restrictions set out by the health care provider:
- have pre-determined light duties available to accommodate immediate return to work when possible
- use a written modified work agreement and send a copy to WCB-Alberta
- pay injured workers their pre-accident rate of pay while on modified work, or advise WCB-Alberta if that is not the case

*Helpful Links:

<table>
<thead>
<tr>
<th>What is Modified Work?</th>
<th>Develop a Modified Work Program</th>
<th>Modified Work Agreement</th>
</tr>
</thead>
</table>

Employers cannot:
- deduct the cost of WCB-Alberta premiums from worker wages or from benefits paid to workers
- discourage or impede a worker from reporting a work-related injury/illness
- directly pay for lost wages or medical aid resulting from a work-related injury/illness without WCB-Alberta’s knowledge or approval
- provide or ask a worker to provide false or misleading information about a claim

Injured workers:
- have the right to choose their own health care provider, though you may request they attend a health care provider or OIS clinic of your choosing
- are expected to maintain regular contact with you, WCB-Alberta and their health care provider, and to participate in the treatment and/or rehabilitation required for a successful return to work
- are expected to accept suitable modified work allowing for an early, and safe return to work

WCB’s Claims Audit Self-Evaluator is a checklist to help you identify shortcomings in meeting legislated requirements, detect gaps in managing return to work and improve your injury management process.

*Go to [http://www.wcb.ab.ca/pdfs/employers/EFS_My_worker_is_injured.pdf](http://www.wcb.ab.ca/pdfs/employers/EFS_My_worker_is_injured.pdf) if you have a printed copy of this document and would like to view the Helpful Links.
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
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.

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.

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.
**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**

**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.

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Important: Circle the day in the work schedule your worker was injured.
**Employer Details**

- **Business Name or Government Department**: Alberta Education
- **WCB Account Number**: 345912/6
- **Industry**: 
- **Employer/Supervisor Contact Name and Title**: Kelly Roach, Off-Campus Education Coordinator
- **Crescent Heights High School, Medicine Hat**
- **Contact Phone**: 403-527-6641, ext. 8295 or cell 403-504-7890
- **Contact E-mail**: kelly.roach@sd76.ab.ca

**Accident Details**

- **Date/time of accident**: 
- **Time**: __ : __ a.m. p.m.
- **Date/time scheduled shift started**: 
- **Time**: __ : __ a.m. p.m.
- **Date/time scheduled shift ended**: 
- **Time**: __ : __ a.m. p.m.

- **Date accident/injury reported to employer**: 
- **To whom was the accident/injury reported?**: [ ]

- **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:**

"Employer: please indicate below...company name and contact person information as well as the incident description:

__________________________________________________________________________

__________________________________________________________________________

If you have more information, please attach a letter.

- **Motor vehicle accident**: [ ]
- **Cardiac condition/injury**: [ ]
- **Letter attached**: [ ]

- **Did the accident/injury occur on employer’s premises?**: [ ]

- **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?**: [ ]
  - **Were the actions part of the worker’s regular duties?**: [ ]

**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**: 

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.**
**7 Return to Work Details**

a. Will/did you pay the worker regular pay while off 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:  (Hour / Minute / AM/PM)  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
- **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?

- **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:

- **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)

Mark hours worked for one complete work schedule (use zero for days off):

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**IMPORTANT**

Circle day of injury. See instructions 

or if your schedule is more than 21 days, attach a copy of the schedule.
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 Report of Injury or Occupational Disease form and sends it to WCB as soon as possible.

**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.

**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
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 the Worker Handbook.

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.

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.
**Injury Details**

<table>
<thead>
<tr>
<th>What part of body was injured? (hand, eye, back, lungs, etc.)</th>
<th>Left side</th>
<th>Right side</th>
</tr>
</thead>
<tbody>
<tr>
<td>What type of injury is this? (sprain, strain, bruise, etc.)</td>
<td></td>
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</tr>
</tbody>
</table>

**Worker Details**

<table>
<thead>
<tr>
<th>Past the date of injury: Have you been off work?</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Have your work duties been modified?</td>
<td>Yes</td>
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<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Initial</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address: Apt# _____</th>
<th>Social Insurance #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>Province</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone Number</th>
<th>Date of Birth</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Year/Month/Day)</td>
<td>M</td>
</tr>
</tbody>
</table>

| Occupation and job description |

**Employer Details**

<table>
<thead>
<tr>
<th>Employer Business Name</th>
<th>Alberta Education</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>City</th>
<th>Province</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Title</th>
<th>Phone</th>
<th>E-mail</th>
</tr>
</thead>
</table>

**Accident Details**

<table>
<thead>
<tr>
<th>Date/time of accident</th>
<th>Time: ___ : ___</th>
<th>a.m.</th>
<th>p.m.</th>
<th>the injury/condition developed over time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date/time scheduled shift started (if applicable)</th>
<th>Time: ___ : ___</th>
<th>a.m.</th>
<th>p.m.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date/time scheduled shift ended (if applicable)</th>
<th>Time: ___ : ___</th>
<th>a.m.</th>
<th>p.m.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of person and their position</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

If not reported immediately, give the reason:

5. Describe fully, based on the information you have, what happened to cause this injury or disease. Please describe what you were doing, including details about any tools, equipment, materials, etc. you were using. State any gas, chemicals or extreme temperatures you may have been exposed to:

Worker: please indicate...company name and the incident description:

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

<table>
<thead>
<tr>
<th>Full name of treating hospital or healthcare professional</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>

**Injury Details**

<table>
<thead>
<tr>
<th>What part of body was injured? (hand, eye, back, lungs, etc.)</th>
<th>Left side</th>
<th>Right side</th>
</tr>
</thead>
</table>

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

---

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.

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

Employment Details
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 subcontractor or do piecework.

Earnings Details
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.

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 Details
a) Number of hours
Indicate your regular hours of work. Do not include overtime here.
Worker's Last Name:  Worker's First Name:    Initial:
Social Insurance #:  Date of Birth:  (Year / Month / Day)

**Return to Work Details**  Please complete all that apply

7. Will/did your employer pay you while off work?  
   - Yes, pre-accident wages  
   - Unknown

b. Date and time you first missed work:  
   (Year / Month / Day)  
   Time: __ : ___  
   a.m.  p.m.

c. If you have 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 you are working modified duties please describe:

**Employment Type Details**  (Complete A or B or C. Select your type of employment.)

8. Permanent position employed 12 months of the year:
   - Permanent full-time  
   - Permanent part-time  
   - Irregular/casual

or  
9. 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:  
     (Year / Month / Day)  
   - Position end:  
     (Year / Month / Day)
   - Estimated, or  
   - Actual

   How many months or days are workers employed in this position? ________________

or  
10. 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.

**Earning Details**

a. Your rate of pay at time of accident: $ ____________ per  
   - Hour  
   - Day  
   - Week  
   - Month  
   - Year

b. Additional taxable benefits:
   - Vacation Pay: ______________  
   - Taken as time off with pay  
   - Paid on a regular basis  

   Please describe:
   - Shift Premium
   - Overtime
   - Other

c. 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.

**Hours of Work Details**

11. Number of hours (not including overtime): ____________ per week

   Describe your work schedule (e.g., Monday to Friday, on Saturday to Sunday, off):
   ____________________________________________________________

   Complete all three pages and sign the form before sending.
Declaration and Consent

I declare that the information in the Worker 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 the Worker Handbook).

• 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.

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 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 also part of the Worker Handbook, intended to help workers with completing the necessary WCB-Alberta forms and understanding the process.
Hurt at work?

Get the immediate first aid you need, then follow these steps.

1. Tell your Employer details of your injury.
   - After receiving notice, your employer must report the 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.
     • Ask about modified work options — what you can do at work while recovering.

2. Tell your Doctor, physiotherapist or chiropractor you were injured at work.
   - They must report the injury to WCB within 48 hours.
   - Ask about modified work options — what you can do at work while recovering.

3. Tell WCB
   Send your Report of Injury form to WCB right away.
   - You can get forms from your employer or report online at www.wcb.ab.ca.

Report early — the sooner WCB gets your information, the faster we can process your benefits.

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

Need more information?
Call toll free 1-866-922-9221 or visit our website at www.wcb.ab.ca

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