WCB Workers' Compensation Board Alberta

P.O. BOX 2415,
EDMONTON, ALBERTA
T5J 2S5

Fax: 427-5863,
1-800-661-1993

WORKER'S REPORT
of Injury or Occupational Disease

Claim Number:

Worker Information

Will you be off work past the day of injury? ☐ Yes ☐ No

Last Name: First Name: Initials:

Address: Social Insurance #:

City: Province: Prov. Health Care #: - Prov.

Postal Code: Home Telephone: Date of Birth: Y M D Sex: ☐ M ☐ F

Occupation and Job Title at time of injury: Self employed? ☐ Yes ☐ No

If yes, account #:

Employer Information

Employer Name or Government Dept.:

Address: Supervisor's Name:

City: Province: Postal Code: Telephone:

Injury or Occupational Disease Information

1. Date and hour of injury: Y M D Hour: ☐ am ☐ pm **OR** Did this condition develop over a period of time? ☐
2. When did you report injury to your employer? Y M D
3. Who did you report it to? Name: Title: Telephone:

If not reported immediately, give reason:

4. Did injury occur on your employer's premises? ☐ Yes ☐ No Location where accident happened (address or general location, province):
5. 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. 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.

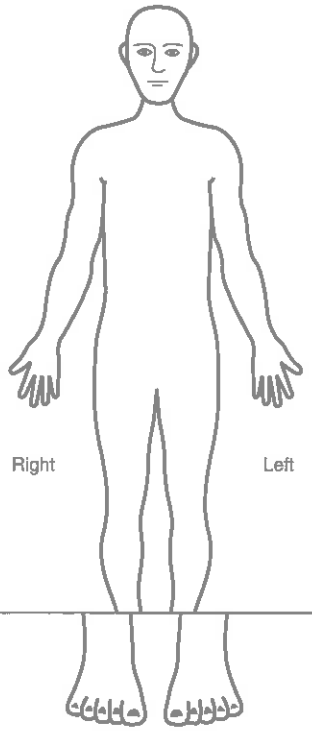
If you have any other information or list of witnesses, attach letter. Letter attached? ☐ Yes

7. What part of body injured? (hand, eye, back, lungs etc.) ☐ Left side ☐ Right side
8. What type of injury is this? (sprain, strain, bruise, etc.)
9. Have you had a similar injury before? ☐ Yes ☐ No **If yes, attach a letter with details**
10. Have you reported or claimed this injury to another WCB? ☐ Yes ☐ No If yes, Province:

Name and address of treating Doctor:

Circle part injured:

Please check: ☐ Front ☐ Back



COMPLETE BOTH SIDES – THIS FORM MUST BE SIGNED ON REVERSE.