Alaska Department of Labor and Workforce Development
Division of Workers' Compensation
P.O. Box 115512, Juneau, AK 99811-5512

REPORT OF OCCUPATIONAL INJURY OR ILLNESS

AWCB Case Number (division use only)

EMPLOYEE: Answer ALL questions 1-20, sign, and give to your employer immediately.

1. Last Name / First Name / Initial	2. Telephone Number	3. Date of Birth	4. Sex ☐ M ☐ F	5. Social Security Number

6. Mailing Address	7. Residence Address
6a. City / State / ZIP Code	7a. City / State / ZIP Code

8. Place (city/town/village/camp) where Injury/Occupational Illness Happened	9. Date of injury or Exposure to Disease	10. On Employer's Premises? YES ☐ NO ☐

11. Name & Address of Attending Physician	12. Hospitalization In-Patient? YES ☐ NO ☐	13. Name of Hospital
City / State / ZIP Code	City / State / ZIP Code	

14. Describe Part(s) of Body Injured/ Nature of Occupational Illness Left ☐ Right ☐	15. Describe How the Injury or Occupational Illness Happened

16. To all health care providers:

You are authorized to provide my employer (named in box 18), its workers' compensation liability insurance company (box 21), and its claims adjuster (box 22) information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above in box 14. This information will be used to evaluate my entitlement to receive benefits, including payment of medical benefits, under the Alaska Workers' Compensation Act. This authorization is valid for a one-year period from the date of my signature (box 17a). I know I have a right to receive a copy of this authorization and agree a photographic copy of this authorization is as valid as the original.

Employee/Patient's signature:

17. If employee Unavailable for Signature, explain circumstances in this space:	17a. Date Signed

EMPLOYER: Review employee answers 18-20, answer questions 21-49.

18. Employer's Name	19. Employer's Alaska Address (if different from mailing)

20. Employer's Mailing Address (street and number)	21. Name of Insurer:

20a. City / State / ZIP Code	20b. Telephone	22. Full Name and Address of Adjusting Company

23. Date Employer First Knew of Injury	24. Date/Time (a.m./p.m.) Employee Left Work	22a. Mailing Address (street and number)

25. Off work after Injury/Illness? YES ☐ NO ☐ 3 or more days? ☐	26. Date returned to Work	27. Death? (Y/N) Date	22b. City / State / Zip	22c. Telephone

28. Location Where Injury or Occupational Illness Happened:	29. Employee's Occupation	30. Date Hired by Employer

31. Earnings Calculated By Hr. ☐ Day ☐ Output ☐ Wk. ☐ Mo. ☐ Year ☐	32. Rate of Pay $_____per_____	33. Days Employee Works per Week 3 or less ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐	34. Describe Scheduled Days Off

35. Workday Began: AM ☐ PM ☐	36. Employee Paid for Day Injured or Ill? YES ☐ NO ☐	37. Federal EIN #	38. Give Details of How Injury or Illness Happened

39. Injury/Illness Due to Machine /Product Failure? YES ☐ NO ☐	40. Mechanical Guard/Safeguards Provided? YES ☐ NO ☐	41. List any machine/substance/object causing injury	42. If machine, what part?

43. Names and Addresses of Witnesses	44. If Injury/Illness Caused by Anyone Besides Employee, Give Name/Address
	45. Dependents (in case of death), Names/Addresses

46. If You Doubt Validity of Injury or Illness, State Reason:

47. Signature of Authorized Employer Representative	48. Title	49. Date Signed

WARNING TO EMPLOYEES AND EMPLOYERS: AS 23.30.250 imposes civil penalties for fraud as well as certain false or misleading statements and acts. Criminal penalties for theft by deception (including fines and incarceration) apply to knowingly made false statements, claims, or employee misclassifications.

Distribution: Original – Workers' Compensation Division; Copy – Adjuster; Copy – Employer; Copy – Employee

Instructions for **REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

TO THE EMPLOYEE

You must complete and sign the "EMPLOYEE" section, questions 1-17, and answer questions 18-20 in the "EMPLOYER" section of this form. Keep a copy for your records. Immediately give this form to your employer. The employer will then complete their portion, and forward copies to their insurer, their claims administrator, and the Workers' Compensation Division. You should notify your employer immediately, but no later than 30 days after your injury occurred or illness began.

After obtaining medical treatment, tell your health care provider's office to complete and mail the required "Physician's Report" (form 07-6102) to your employer's insurer for payment and to the Workers' Compensation Division for your file. A completed report is a requirement for payment under AS 23.30.095(c).

If you, your employer, and your doctor promptly file the required reports, there should be no delay in payment of compensation. You will not be paid compensation for lost wages for the first three days off work unless your disability lasts more than 28 days. The first installment of compensation becomes due on the 14th day after the employer has knowledge of the injury, illness or disease. After the first payment, you should get a check every two weeks while you are disabled. If you have not received payment within 21 days from the date you were injured or became ill, contact the insurer or adjuster first. If you have any questions or problems, contact the Workers' Compensation Division office nearest you (contact information listed below). If you are off work for 3 or more days, you will need to provide additional information to your employer's claims adjuster regarding your wages, marital status, and number of dependents.

If you believe your work related injury or illness will keep you from returning to your job at the time of injury, you may need retraining. The training benefits to which you may be entitled, and how you go about getting them, depend on your date of injury. If you are off work for 45 days, contact the division office in Anchorage to learn more about your rights for reemployment benefits. You may also refer to the Reemployment Benefits section of the "Workers' Compensation and You" brochure available at the Division's internet web page:

www.labor.state.ak.us/wc

INFORMATION IN FILES MAINTAINED BY THE DIVISION OF WORKERS' COMPENSATION, EXCEPT FOR MEDICAL AND REHABILITATION RECORS, IS AVAILABLE FOR PUBLIC REVIEW AND COPYING FOR NONCOMMERCIAL PURPOSES. AS 23.30.107

TO THE EMPLOYER

This form must be completed and mailed immediately, and in no case later than **ten days** after you have knowledge that your employee has been injured, or claims to have been injured or become ill while working for you. Be certain to mail a completed copy to the Workers' Compensation Division within the required 10-day period. Failure to file this report within the required time may subject you and/or your insurer to a penalty equal to 20 percent of the amount of compensation due to the injured worker. AS23.30.070

File the original of this form with the Alaska Division of Workers' Compensation, P.O. Box 115512, Juneau, AK 99811-5512. Keep a copy for your records, give a copy to the injured employee, and send a copy to your insurer's claims adjuster. If you believe the employee will be unable to work for more than three days because of injury or illness, be certain to complete items 31, 32, 33, and 34, or contact your insurer's claims adjuster and provide information about the injured employee's earnings. (Your insurer's claims adjuster is **NOT** the agent or broker from whom you purchased your workers' compensation liability insurance policy).

OSHA REQUIREMENTS

Report industrial deaths and accidents to the Division of Labor Standards and Safety.
Alaska Statute 18.60.058 requires employers to report to the Division of Labor Standards and Safety any employment accident which is fatal to one or more employees or which results in the overnight hospitalization of one or more employees. The report, which must be made immediately, but no later than 8 hours after receipt by the employer of information that the accident has occurred, must relate the circumstances of the accident, the number of fatalities, and the extent of the injuries.

Monday-Friday Alaska OSH (800) 770-4940 • 24-hour OSHA Hotline (800) 321-6742

> "*Injury*" means accidental injury or death arising out of and in the course of employment and an occupational disease, illness, or infection which arises naturally out of the employment or which naturally or unavoidably results from an accidental injury.
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> "*Injury*" does not include mental injury caused by stress unless it is established that (A) the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment, and (B) the work stress was the predominant cause of the mental injury. A mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by the employer.

	Alaska Worker's Compensation Division Offices:	Alaska Labor Standards and Safety Division Offices:
Anchorage:	3301 Eagle St, #304 PO Box 107019 Anchorage, AK 99510-7019 (907) 269-4980	3301 Eagle St, #301 PO Box 107022 Anchorage, AK 99510-7022 (907) 269-4940 or (800) 770-4940
Fairbanks:	675 Seventh Ave, Station K Fairbanks, AK 99701-4586 (907) 451-2889	
Juneau:	1111 West 8th St, #307 PO Box 115512 Juneau, AK 99811-5512 (907) 465-2790	1111 West 8th St, #304 PO Box 020630 Juneau, AK 99802-0630 (907) 465-4855