Department of Labor and Workforce Development
Alaska Workers' Compensation Board
P.O. Box 25512, Juneau, Alaska 99802-5512

REPORT OF OCCUPATIONAL INJURY OR ILLNESS

AWCB Case Number

EMPLOYEE: Answer questions 1-20, immediately mail report. Further instructions on GREEN AND YELLOW page.

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
City State Zip Code	City State Zip Code
8. City, Town, Village where injury occurred	9. Date & Hour of Last Exposure to Injury or Disease Date Hour ☐ AM ☐ PM; 10. On Employer's Premises? ☐ Yes ☐ No
11. Full Name and Address of Attending Physician	12. Hospitalized as In-Patient? ☐ Yes ☐ No; 13. Name and Address of Hospital
City State Zip Code	City State Zip Code
14. Type of Injury or Illness and Part of Body Injured ☐ Left ☐ Right	15. Describe How the Injury or Illness Happened
	16. Employee's Signature (If not available, explain); 17. Date Signed

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
City State Zip Code; Telephone	22 Full Name and Address of Adjusting Company
23. Date Employer First Knew Injury or Illness was Work Related; 24. Time Employee Left Work Date Hour ☐ AM ☐ PM	Mailing Address (street and number)
25. Time Lost Beyond Date of of Injury or Illness? ☐ Yes ☐ No; 26. Date Returned to Work; 27. Death ☐ Yes ☐ No Date	City State Zip Code; Telephone

28. Location Where Injury or Illness Took Place	29. Employees 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. Name Scheduled Days Off	35. Workday Began ☐ AM ☐ PM

36. Was Employee Paid for Day of Injury or Illness? ☐ Yes ☐ No	37a. Federal EIN Number	37b. U I Account Number	38, Give Details of How Injury or Illness Happened

39. Was Injury or Illness Caused by Failure of a Machine or Product? ☐ Yes ☐ No	40. Were Mechanical Guards or Other Safeguards Provided? ☐ Yes ☐ No	41. Name Machine, Substance or Object Which Directly Injured Employee	42 If Mechanical, Specifically What Part?

43. Names and Addresses of Witnesses	44. If the Injury or Illness Was Caused by Anyone Besides Employee, Give Name and Address

45. Dependents (name and address in case of death)

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

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

PRESS HARD 3 COPIES

WARNING TO EMPLOYEES AND EMPLOYERS: Penalties for fraud or misleading statements. A person who knowingly makes a false or misleading statement that adversely affects another person, is guilty of deception as defined in AS 11.46.180, and may be punished as provided in AS 11.46.120-150.

See Instructions on Back of Pink and Yellow Pages

Distribution: Blue-Workers' Comp Board White-Adjusting Co. Pink-Employer's File Green & Yellow-Employee

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EMPLOYEE: READ AND FOLLOW THE INSTRUCTIONS BELOW

DECLARE YOUR MARITAL STATUS AND THE NUMBER OF YOUR ACTUAL DEPENDENTS ON THE INJURY DATE. "ACTUAL DEPENDENTS" MEANS THE EXEMPTIONS YOU WOULD BE ABLE TO CLAIM IF YOU WERE FILING YOUR INCOME TAX RETURN.

1. MARITAL STATUS: ☐ SINGLE ☐ MARRIED, SPOUSE'S FULL NAME ______________________

2. DEPENDENTS:
   - a. ☐ YOURSELF ☐ 65 OR OVER ☐ BLIND
   - b. ☐ SPOUSE ☐ 65 OR OVER ☐ BLIND
   - c. ☐ List first names and birthdates of your dependent children who live with you:

     Enter number of boxes checked in (a) and (b) ☐

     ____

     Enter number of children listed ☐

   - d.

Other Dependents (1) Name	(2) Relationship	(3) Do you provide more than % of dependent's support?

Enter number of other dependents ☐

Always check the box labeled "Yourself."
Check other boxes if they apply.

e. Total Number of Dependents Claimed --

Add numbers entered in boxes above ☐

Employee's Signature	Date

IMPORTANT!
TURN PAGE OVER AND COMPLETE FORM

TO THE EMPLOYEE

Obtain first aid or medical treatment immediately. Ask your doctor to mail a "Physician's Report" (07-6102) to the insurer and the Workers' Compensation Board.

Notify your employer about your injury or illness. Complete the "EMPLOYEE" section, questions 1-20 of this form. Keep the green copy. Immediately give all the other copies of this form to your employer. Once the employer's section of the form is complete, the employer will give you the yellow copy.

If you, your employer, and your doctor promptly file reports there should be no delay in payment of compensation. You will not be paid for the first three (3) days of the disability 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 Office nearest you.

If you believe your work-related injury or illness will keep you from returning to your job at the time of injury and you may need retraining, YOU MUST REQUEST IN WRITING AN ELIGIBILITY EVALUATION WITHIN 90 DAYS AFTER YOU REPORT YOUR INJURY OR ILLNESS TO YOUR EMPLOYER. If 90 days have passed and you want a reemployment evaluation but have not requested one, you need to request in writing an evaluation and explain why you did not make the request within 90 days of the injury. To learn more about reemployment benefits, please read the Reemployment Section of the "Workers' Compensation and You" brochure which will be mailed to you after your claim is set up with the Workers' Compensation Division. If you have questions about reemployment benefits, call (907) 269-4980 and ask to speak to someone in the reemployment section.

	Alaska Workers' Compensation Division Offices:	Division of Labor Standards and Safety Offices:
Anchorage:	3301 Eagle Street, #304 P.O. Box 107019 Anchorage, AK 99510-7019 (907) 269-4980	3301 Eagle Street, #301 P.O. Box 107022 Anchorage, AK 99510-7022 (907) 264-4900
Fairbanks:	675 Seventh Avenue, Station H2 Fairbanks, AK 99701-4586 (907) 451-2889	
Juneau:	1111 West 8th Street, #307 P.O. Box 25512 Juneau, AK 99802-5512 (907) 465-2790	1111 West 8th Street, #304 P.O. Box 21149 Juneau, AK 99802-1149 (907) 465-4842

ALL INFORMATION IN THE WORKERS' COMPENSATION BOARD FILES, EXCEPT MEDICAL AND REHABILITATION RECORDS, IS AVAILABLE FOR PUBLIC REVIEW AND COPYING.

TO THE EMPLOYER

This form must be completed and mailed immediately and in no case later than **ten (10) days** after you have knowledge that your employee has been injured or claims to have been injured while working for you. Distribute copies of the form as follows:

Blue Copy	Alaska Workers' Compensation Board P.O. Box 25512 Juneau, AK 99802-5512
White Copy .... (attach employee's earnings information)	Your Adjuster or Insurance Company (not your Agent or Broker)
Pink Copy	Employer's File
Yellow and Green Copies	Employee

"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.

"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.

Failure to file this report within the required time may subject you and/or your insurer to a penalty equal to 20% of the amount of compensation due plus interest to the injured worker.

If you believe the employee will be unable to work for more than three days because of injury, contact the adjuster or insurer and provide information about employee's earnings.

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 an 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 24 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.

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IF YOU BELIEVE THAT YOU WILL NOT BE ABLE TO WORK FOR MORE THAN THREE (3) DAYS BECAUSE OF YOUR INJURY OR ILLNESS, IMMEDIATELY FILL OUT THE FORM BELOW AND SEND IT TO THE ADJUSTING COMPANY, INSURER, OR EMPLOYER LISTED IN #21 OR #22 ON REVERSE SIDE OF THIS FORM.

Check the BOXES which are true for you. Attach wage stubs or records about your earnings as indicated, including deferred income, employer-provided room and board, and employer contributions to a qualified pension or profit-sharing plan.

1. ❒ When injured I was a seasonal/temporary worker. ATTACH EARNING RECORDS FOR ALL WORK FOR THE CALENDAR YEAR IMMEDIATELY BEFORE THE INJURY.

   IF YOU CHECKED BOX NUMBER ONE ABOVE, SKIP TO NUMBER FIVE (5) BELOW.

2. ❒ I was employed less than 13 calendar weeks immediately before the injury. YOU DO NOT NEED TO ATTACH EARNING RECORDS.

3. ❒ I was employed 13 calendar weeks or more immediately before the injury.

   a. ❒ When injured, my wages were calculated by the: ❒ Week ❒ Month ❒ Year ATTACH EARNING RECORDS IF YOU WORKED FOR MORE THAN ONE EMPLOYER.

   b. ❒ When injured, my wages were calculated by the day, hour, or output. IF YOU WERE EMPLOYED 13 WEEKS OR MORE, ATTACH EARNING RECORDS FOR YOUR MOST FAVORABLE 13 CONSECUTIVE CALENDAR WEEKS WITHIN THE 52 WEEKS IMMEDIATELY BEFORE YOUR INJURY.

4. ❒ When injured, my wages or the basis for my pay had not been set. ATTACH INFORMATION ABOUT THE USUAL WAGE FOR SIMILAR SERVICES.

5. ❒ When injured, I was employed by two or more employers.

6. ❒ When injured, I was a minor, apprentice, or trainee in a formal training program.

7. ❒ I was injured working as a volunteer ambulance attendant, volunteer police officer, or volunteer fire fighter.

8. ❒ I was injured before September 4, 1995.

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