Alaska Dept of Labor and Workforce Development
Division of Workers' Compensation
PO Box 115512 | Juneau, AK | 99811-5512
workerscomp@alaska.gov

REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Date Received (Division Use Only):

EMPLOYEE:

1. Last Name	First Name	Initial	2. Date of Birth	3. Social Security Number	
4a. Mailing Address			5. Telephone Number	6. E-Mail Address	
4b. City	State	Zip Code	7. Marital Status	8. # of Dependents	9. Gender
10. Location (City/Town/Village/Camp) Where Injury or Occupational Illness Happened			11. Date of Injury or Illness	12. Time of Injury or Illness	13. On Employer's Premises? ◯ YES ◯ NO
14. Part(s) of Body Injured ☐ Left ☐ Right			15. Describe Nature of Injury / Illness (i.e., sprain, laceration, etc)		

16. Describe How Injury or Occupational Illness Happened

17. Initial Treatment

◯ No Medical Treatment
◯ Minor On-site Remedies by Employer Medical Staff
◯ Minor Clinic/Hospital Remedies and Diagnostic Testing
◯ Emergency Evaluation, Diagnostic Testing, and Medical Procedures
◯ Hospitalization Greater than 24 Hours
◯ Future Major Medical/Lost Time Anticipated

18. Witness Name(s) and Phone Number(s)

19. To all health care providers:

You are authorized to provide my employer, its workers' compensation liability insurance company, and its claims adjuster information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above. 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. 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.

20. Employee Signature: **Date Signed**

21. If Employee Unavailable to Sign, Explain the Circumstances

EMPLOYER:

22. Employer Name	FEIN		23. Insurance Policy Number	Effective Date	Expiration Date
24a. Employer Mailing Address			25. Insurer Name		FEIN
24b. City	State	Zip Code / 24c. Telephone	26. Claim Administrator Name		FEIN
27. Employer E-Mail Address			28a. Claim Administrator Mailing Address		
29. Date Employer First Knew of Injury / Illness	30. If Fatal, Date of Death		28b. City	State	Zip Code
31. Off Work After Injury / Illness? ◯ YES ◯ NO ☐ 4 or More Days?	32. Date Returned to Work		33. Employee Occupation / Job Title		
34. Rate of Pay	35. Earnings Calculated By ◯ Hr. ◯ Day ◯ Output ◯ Wk. ◯ Mo. ◯ Yr.		36. Employee Paid for Day Injured or Ill? ◯ YES ◯ NO		

37. Provide Any Additional Details of How Injury or Illness Happened. If You Doubt Validity of Injury or Illness, State Reason.

38. Signature of Authorized Employer or Representative	**39. Title**	**40. 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 misclassification of employees.

Alaska Division of Workers' Compensation Offices
workerscomp@alaska.gov

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(907) 269-4980

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Juneau, AK 99811-5512
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675 Seventh Avenue, Station K
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Instructions for
REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TO THE EMPLOYEE

You must report your injury or illness to your employer **within fifteen (15) days** of the date it occurred or began. Failure to report within this timeframe may impact your eligibility for benefits.

This form is provided for convenience, but use of this specific form is not required by the Division of Workers' Compensation. Many insurers or claims administrators have their own forms or reporting processes, so your employer may provide you with different paperwork. Your employer is required to report your injury to the Division through its insurance carrier via electronic data interchange (EDI). When your employer files the report of injury, the Division will send you notice that a case has been established. If you choose to use this form to notify your employer, keep a copy for your records and submit it to your employer as soon as possible.

After obtaining medical treatment, ask your health care provider to submit a Physician's Report (8 AAC 45.086) to your employer.

You will not be paid compensation for lost wages for the first three (3) 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 (2) weeks while you are disabled. If you have not received payment within 21 days after the date you were injured or became ill, contact the insurer or adjuster first. If you have any questions or problems, contact the Division of Workers' Compensation office nearest you. If you are off work for three (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 injury or illness may prevent you from returning to your prior job, you may be eligible for reemployment benefits. If you are off work for 25 days or more, contact the Division's Anchorage office to learn more. You can also refer to the *Workers' Compensation & You* brochure available at: https://labor.alaska.gov/wc/

TO THE EMPLOYER

The injury must be reported to the Division through your insurer or claims administrator via electronic data interchange (EDI) within **ten (10) days** of your knowledge of the injury or illness, in accordance with AS 23.30.070. Failure to report the injury through EDI within the required timeline may result in a **penalty of 20% on the compensation owed** to the injured worker. You may use this form to collect information from your employee or assist in compiling the required data for your insurer. Keep a copy of any completed forms for your records.

> *Injury* means accidental injury or death arising out of and in the course of employment, and an occupational disease or infection that 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.

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 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