UNIVERSITY OF ALBERTA

Employer's Report
of Injury or Occupational Accident

Employee Information ☐ **Lost Time** ☐ **No Lost Time** ☐ **Modified Duties**

Last Name ______ First Name ______

Address ______ City ______

Province ______ Postal Code ______

Home Phone ______ Occupation ______

Date of Birth ______ (yyyy/MM/dd) Sex Male ☐ Female ☐

Social Insurance # ______ Provincial Health Care # ______ Province ______

Employer Information

Employer Name University of Alberta – Human Resources Employer Account # 142019

Address 2-40 Assiniboia Hall City Edmonton Province Alberta Postal Code T6G 2E7

Contact Name Sharon Fackrell Phone Number 492-0207 Fax Number 492-0798

Does the injured worker have personal coverage? Yes ☐ No ☐ Is the injured worker a partner or director in this business? Yes ☐ No ☐

Injury or Occupational Disease Information

1. Date of Injury (yyyy/MM/dd) Time of Injury am ☐ pm ☐ **OR** Did this condition develop over a period of time? Yes ☐ No ☐

Hours of employment on the day of accident From ______ To ______

2. When was the injury reported to the employer? Year Month Day

3. Did the injury occur on employer premises? Yes ☐ No ☐ Did the injury occur in Alberta? Yes ☐ No ☐

Location where accident happened (address or general location) ______

4. 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 the worker may have been exposed to.

5. What part of the body was injured? (hand, eye, back, lungs, etc. ______ Left Side ☐ Right Side ☐

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

7. Were the worker's actions at the time of the injury for the purpose of your business? Yes ☐ No ☐

8. Were the actions part of the worker's regular duties? Yes ☐ No ☐

9. **No Lost Time** ☐ **Modified Duties** ☐ ➢ **Sign first page and send to the WCB**
Lost Time ☐ **Modified Duties** ☐ ➢ **Complete Second Page**

Supervisor's Name ______ Date ______ (yyyy/MM/dd)

If you have any other information that would help us make a decision, or you have concerns, please attach a letter. Please check this box if a letter is attached. ☐

Last Name ______ First Name ______

Social Insurance Number Date of Birth Year Month Day

Lost Time / Return to Work Information

10. A. Date and time worker first missed work Year Month Day Time am ☐ pm ☐

B. If worker has returned to work, indicate date. Has the worker returned to: regular work ☐ or modified work ☐? Year Month Day Time am ☐ pm ☐

C. Do you have modified duties the worker can perform until they are ready to return to their regular job? Yes ☐ No ☐

D. Will you continue the worker on pay during the period of disability? Yes ☐ No ☐ Gross Amount $

E. Indicate date the worker was hired (yyyy/MM/dd)

Type of Employment – Fill in A or B or C

11. A. Permanent full time ☐ Permanent Part time ☐

B. Seasonal Work ☐ Summer Student ☐ Irregular / Casual ☐ Temporary ☐
Had this injury not happened, what would have been your worker's last day of employment? (yyyy/MM/dd)
Is this an estimated date ☐ or actual ☐ ?
How many months or days per year do you employ people in this position?

C. Sub Contractor ☐ Piece Work ☐ Vehicle Owner/Operator ☐ Welder Owner/Operator ☐ Apprentice ☐
Other or self employment ☐ Explain

(Please also ask your employee to submit a detailed income and expense statement if you check any box in 11. C.)

Wage Information

12. A. Workers Rate of Pay $ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other ☐

B Additional Taxable Benefits

Vacation/Stat Holiday Pay ☐ % ➢ Taken as time off with pay ☐ Paid on regular basis ☐
Shift Premium # 1 ☐ Amt. ➢ Paid Per:
Shift Premium # 2 ☐ Amt. ➢ Paid Per:
Regular Overtime ☐ Rate ➢ Number of Hours per: week ☐ month ☐ shift cycle ☐
Other ☐ Explain ➢ Amount per: week ☐ month ☐ shift cycle ☐

(Note: Only complete Question 13 if you are unable to complete Question 12. – Usually applies to seasonal or irregular/casual workers)

13. A. Gross earnings for the period of one year or less $ from (yyyy/MM/dd) (12 months or less prior) to (yyyy/MM/dd) (date before injury)

B. Was any time missed from work without pay during the above period? (e.g. maternity, sick, work shutdown, WCB benefits, etc. – not vacation). If yes, number of days. Yes ☐ No ☐
Reason:

Hours of Work

14. A. Number of hours per Day ☐ Week ☐ Shift Cycle ☐ Other ☐

B. Does the work schedule repeat? Yes ☐ Mark the hours worked for one complete work schedule (use zero for days off) **OR if your schedule is more than 21 days, attach a copy of the schedule. Start with the week of the accident.**

	Sun	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**
Hrs. per day							
Hrs per day							
Hrs. per day							

No ☐ Report average hours worked per week

C. Date the shift cycle commenced (yyyy/MM/dd)

Earnings Information Contact: Sharon Fackrell (780) 492-0207