



Workers' Compensation Board

Alberta

P.O. BOX 2415
EDMONTON AB T5J 2S5

Phone **780-498-3999** (in Edmonton)
1-866-922-9221 (toll free in Alberta)
1-800-661-9608 (outside Alberta)
Fax **780-427-5863** or **1-800-661-1993**

March 2008

EMPLOYER'S REPORT of Injury or Occupational Disease C040

Seven Digit Claim #:

Claim Type	<input type="checkbox"/> Time Lost	<input type="checkbox"/> Modified Work	<input type="checkbox"/> Fatality	<input type="checkbox"/> No Time Lost (Notice of non-disabling injury/illness)
	Complete entire report if claim type is one of the above			Complete first page only

Worker Information				
Last Name:	Former Name: (e.g., maiden name)	First Name:	Initial:	
Address:		Apt #:	Social Insurance #:	
City:	Province:	Postal Code:	Health Care #:	Province:
Daytime Phone:	Evening Phone:	Date of Birth:	(Year / Month / Day)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Occupation:		Apprentice: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Employer Information				
Business Name or Government Department:		WCB Account Number:	Industry:	
		Does the injured worker have WCB personal coverage with this business? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mailing Address:		Is injured worker a proprietor, partner or director in this business? <input type="checkbox"/> Yes <input type="checkbox"/> No		
City:		Employer/Supervisor Contact Name:		
Province:	Postal Code:	Phone:		
Phone:	Fax:	E-mail Address:		

Injury or Occupational Disease information				
1	Date and time of injury:	(Year / Month / Day)	Time:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> This condition developed over a period of time.
	Scheduled hours of employment on the day of accident:	From:	To:	
2	When was someone at your business notified of the injury?	(Year / Month / Day)	Time:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
	Name of person and their position:	Position:		
3	Did the injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did injury occur in Alberta? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Location where the 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 worker may have been exposed to:			
	If you have more information, please attach a letter. Letter attached? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5	What part of body injured? (hand, eye, back, lungs, etc.)	<input type="checkbox"/> Left side <input type="checkbox"/> Right side		
6	What type of injury is this? (sprain, strain, bruise, etc.)			
7	Were the worker's actions at the time of injury for the purpose of your business? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8	Were the actions part of the worker's regular duties? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Check the box that best describes the physical demands of the regular duties: <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy (See detailed description on page 2 of attached instructions)			
9	Indicate type of aid provided: <input type="checkbox"/> First aid <input type="checkbox"/> Medical aid (Name of treating healthcare professional/hospital): _____ <input type="checkbox"/> None			

Was a copy of this report given to the injured worker as per the *Workers' Compensation Act*? Yes No Worker declined it

Employer's Signature: _____ Date: _____ (Year / Month / Day)

(for office use only)



C-040 REV MAR 2008

If you have any other information that would help us make a decision, or if you have concerns, please attach a letter.
THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH A DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW OR APPEAL.

Worker's Last Name: _____ Worker's First Name: _____ Initial: _____
 Social Insurance #: _____ 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: a.m. p.m.
 b. Will/did you pay the worker while off work? Yes No
 If yes, will/did you pay: Pre-accident rate of pay and hours of work | Other Rate: \$ _____ per _____, or Number of hours: _____ per _____, or gross amount: \$ _____
 For the period from: _____ (Year / Month / Day) to _____ (Year / Month / Day)
 c. If the worker has returned to work indicate date: _____ (Year / Month / Day) Time: a.m. p.m.
 Check: Regular work duties, or Modified work duties Regular hours of work, or Modified hours of work _____ hrs per _____
 Pre-accident rate of pay, or Revised rate of pay \$ _____ per _____
 d. If the worker is not back at work are you able to modify work duties/hours to accommodate an early return? Yes No Was offered but the worker declined

Type of Employment (Complete A or B or C)

11 **A** Permanent position employed 12 months of the year: Full-time Part-time
or B Non-permanent position employed only part of the year (subject to seasonal or lack of work layoffs):
 Seasonal worker Temporary position Casual as needed Volunteer Summer student
 Had this injury not occurred the worker's last day of employment would have been: _____ (Year / Month / Day) Estimated or Actual
 How many months or days per year do you employ people in this position?
or C Special employment circumstance: Contractor/sub contractor Vehicle owner/operator Welder owner/operator Commission
 Piece work Other/self-employed
 Does the worker incur expenses to perform the work (materials, tools, etc.)? Yes No Will the worker receive a T4? Yes No
Note: If you have checked any box in 11C, have the worker submit a detailed income and expense statement.

Wage Information

Date the worker was hired: _____ (Year / Month / Day)
12 a. Worker's rate of pay at time of accident: \$ _____ Hourly Weekly Bi-weekly Semi-monthly Monthly Other:
 b. Additional taxable benefits:
 Vacation Pay Included in rate of pay %: _____ OR Taken as time off with pay
 Stat Holiday Pay Included in rate of pay %: _____ OR Taken as time off with pay
 Shift Premium # 1 Amount: \$ _____ → Paid per:
 Shift Premium # 2 Amount: \$ _____ → Paid per:
 Regular Overtime Rate: \$ _____ → Number of hours: _____ per Week Month Shift cycle
 Other Explain: _____ → Amount: _____ per Week Month Shift cycle
13 a. Gross earnings for the period of one year or date the worker was hired if less than one year: \$ _____ from: _____ (Year / Month / Day) to: _____ (Year / Month / Day)
 (12 months or less prior) (date of injury)
 b. Was any time missed from work **without pay** during the above period, excluding vacation? (eg. maternity, sick, work shutdown, WCB benefits) Yes No
 If yes, number of days: _____ Reason: _____

Hours of Work

14 a. Number of hours (not including overtime): _____ per Day Week Shift cycle Other:
 b. Does the work schedule repeat? No Yes → Mark hours worked for one complete work schedule (use zero for days off):
 Average hours worked per week: _____

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Hours per day:							
Hours per day:							
Hours per day:							

IMPORTANT: Circle day of injury. See instructions
 c. Date shift cycle commenced: _____ (Year / Month / Day)
or If the worker's schedule is more than 21 days, attach a copy of schedule.

Earnings Information Contact (please print): _____ Phone Number: _____

