ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
P.O. Box 1149
Juneau, Alaska 99802

# REPORT OF OCCUPATIONAL INJURY OR ILLNESS

AWCB Case Number

DO NOT WRITE IN THIS COLUMN

## NOTICE TO EMPLOYER

## EMPLOYEE: PLEASE ANSWER ALL QUESTIONS

1. Name (Last, First, Middle Initial)
2. Telephone
3. Date of Birth / /
4. Sex ☐ M ☐ F
5. Soc. Sec. Number
6. Street and Number (Permanent Address)
City State Zip Code
7. Street and Number (Current Mailing Address if Different)
City State Zip Code
8. Place of Injury or Exposure (City, Town, Village)
9. Date & Hour of Injury or Exposure to Disease
Date / / Hour ☐ AM ☐ PM
10. On Employer's Premises? ☐ Yes ☐ No
11. Full Name and Address of Attending Physician
City State Zip Code
12. Hospitalized as In-Patient? ☐ Yes ☐ No
13. Name and Address of Hospital
City State Zip Code
14. Nature of Injury or Diagnosis and Part of Body Affected ☐ Left ☐ Right
15. Describe How the Injury or Illness Occurred (What Happened)
16. Employee's Signature (If not Available, Explain)
17. Date Signed / /

FIPS Code
Occupation
Nature of Injury
Part of Body
Source
Type
Length of Service
Weekly Wage
Extent
Ins.

## REPORT OF INJURY OR ILLNESS

## EMPLOYER: PLEASE ANSWER ALL QUESTIONS

18. Employer's Name
19. Employer's Alaska Address (If Different from Mailing)
20. Employer's Mailing Address (Street and Number)
City State Zip Code
Telephone
21. Name of Insurer
22. Full Name and Address of Adjusting Company
Mailing Address (Street and Number)
City State Zip Code
Telephone
23. Date Employer First Knew Injury Is Work-Related / /
24. Time Employee Left Work
Date / / Hour ☐ AM ☐ PM
25. Will Injury Result in Lost Time Beyond Date of Accident? ☐ Yes ☐ No
26. Date Returned to Work / /
27. Fatality (Death) ☐ Yes ☐ No Date / /
28. Place Where Injury or Exposure Occurred if Different from Employer's Mailing Address
29. Employee's Occupation
30. Department in Which Employee Regularly Employed
31. Date Hired with Present Employer / /
32. Wage (Incl. Board, Room, Gratuities)
$ ☐ Hr. ☐ Day ☐ Wk. ☐ Mo.
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? ☐ Yes ☐ No
37. Alaska Unemployment Insurance Account Number (U.I. Acct. No.)
38. How Did the Accident Occur? (Give Details)
39. What Was the Employee Doing When the Injury or Illness Occurred? (Be Specific)
40. Was Accident Caused by Failure of a Machine or Product? ☐ Yes ☐ No
41. Were Mechanical Guards or Other Safeguards Provided? ☐ Yes ☐ No
42. Name Machine, Substance or Object Which Directly Injured Employee
43. If Mechanical, Specifically What Part?
44. Names and Addresses of Witnesses
45. If the Accident Was Caused by Anyone Besides Employee, Give Name and Address
46. Dependents (Name and Address in Case of Death)
47. If You Doubt Validity of Claim, State Reason
48. Signature of Authorized Employer Representative
49. Title
50. Date Signed / /

Form 07-6101 (Rev. 8/85)
DISTRIBUTION: Blue-Workers' Compensation Board
White-Adjusting Company Pink-Employer's File
Yellow and Green-Employee

EMPLOYER: Answer questions 18-50 fully, and **immediately** send report. Further instructions on back.

EMPLOYEE: Answer questions 1-17 fully. Carefully read and follow instructions on front and back of green copy. **VERY IMPORTANT.**

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