



Proper Reporting of a Workplace Injury

In the event of a workplace injury, Members should immediately report it to APRA, your Workers' Compensation Insurer.

- Within 15 days of a workplace injury, the employee must notify (in writing) a person in a supervisory or management role. Telling a co-worker does not qualify as proper notice of a workplace injury.
 - An employer has 10 days under Alaska law from the time they are aware of a workplace injury to file the Employer and Employee Report of Injury Forms. Forward your forms to APRA as soon as possible to avoid penalties and/or processing delays.
 - Claim forms are located at www.alaskarisk.org; click on CLAIMS and then select the PDF Claim Forms.
- WORKERS COMPENSATION** ↻
- Both the Employee and Employer Report of Injury Forms must be completed in their entirety. Be sure to sign and date them. The Employee should complete their own form.
 - If the Employee has not completed or returned an Employee Report of Injury Form the Employer should complete one on their behalf indicating the Employee has not returned their completed form to date.
 - Send both the Employer and Employee forms to APRA as both are required to set up a claim file and report electronically to the State of Alaska. APRA will submit them electronically to the State on your behalf.
 - No medical attention or documents are required from the local clinic or health practitioner to report an injury.

Should you have any questions on the forms, whether a report should be filed, or if you doubt the validity of an injury; please contact the Workers' Compensation Claims Department at wccclaims@alaskarisk.org or by calling (907) 560-2010.

Fax forms to: **(833) 520-1660**
or e-mail to: wccclaims@alaskarisk.org

Alaska Public Risk Alliance
807 G Street, Ste. 356
Anchorage, AK 99501
(907)560-2010



**EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS
 TO DIVISION OF WORKERS' COMPENSATION**

EMPLOYER: All questions with an asterisk (*) must be completed									
1. Employer Name*					2. Industry (NAICS) Code Required on New Claims* See http://www.census.gov/cgi-bin/sssd/naics/naicsrch				
3. Employer Contact Name & Telephone						4. FEIN*		5. UI Number	
6. Employer Mailing Address*					7. Employer Physical Address				
City			State		Zip Code		Country, if outside the United States		
City			State		Zip Code		Country, if outside the United States		
8. Employee Name, Last					First		Middle		Suffix
9. Employee Mailing Address*					10. Date of Birth*		11. Date of Death		
City			State		Zip Code		Country, if outside the United States		
12. Employee ID Type & Number*					Country, if outside the United States				
Blocks 13 – 20 are to be completed by the Insurer / Claims Administrator submitting this report to the Division of Workers' Compensation									
13. MTC Report*		14. JCN / AWCB*		15. Claim Status*		16. Claim Type*		17. Late Reason Code	
18. Full Denial Reason Code			19. Full Denial Effective Date			20. Denial Reason Narrative			
21. Policy Information Number			Effective Date			Expiration Date			
22. Insurer Name					23. Insurer FEIN		24. Insurer Type Code*		
25. Claim Administrator Name*					26. Claim Administrator Primary Address*				
27. Claim Admin FEIN*		28. Claim Admin Claim No.*			City		State		Zip Code
29. Claim Admin Physical/Alternate Postal Code*					Country, if outside the United States				
30. Insured Name					31. Insured FEIN		32. Insured Type Code*		
33. Employment Status*		34. Days Worked / Week		35. Wage		36. Wage Period Code		37. Employee Hire Date	
38. Occupation / Job Title					39. Full Wages Paid for Date of Injury Indicator				
40. Employer Paid Salary in Lieu of Compensation Indicator					41. Accident Site Information, if not on Employer Premises				
42. Explain Where Injury Occurred					44. Date of Injury / Illness*		45. Time of Injury / Illness		
43. Accident Premises Code*					46. Date Employer First Knew of Injury / Illness		47. Date Claim Admin Knew of Injury / Illness		
48. Part(s) of Body Affected*					49. Nature of Injury / Illness*				
50. Cause of Injury / Illness*					51. Death Result of Injury Code				
52. Initial Last Day Worked		53. Initial Date Disability Began			54. Initial Return to Work Date		55. Return to Work Type Code*		
56. Return to Work With Same Employer?					57. Physical Restrictions Indicator				
58. Signature of Authorized Employer or Representative					59. Title			60. Date Signed	

Instructions for

**EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO ALASKA
DIVISION OF WORKERS' COMPENSATION**

Employer: This form must be completed and sent 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 or become ill while working for you. You have the option of completing this form electronically or by hand prior to sending the completed to your Insurer/Claims Administrator (Adjuster).

The form should be submitted electronically via electronic data interchange (EDI). If you or your insurer is not registered and approved to submit reports electronically, mail this form (07-6101) and form 07-6100 to the Division of Workers' Compensation, P.O. Box 115512, Juneau, AK 99811-5512. Make sure and keep a copy for your records.

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

AS 23.30.070

**INFORMATION IN FILES MAINTAINED BY THE DIVISION OF WORKERS' COMPENSATION, EXCEPT
FOR MEDICAL AND REHABILITATION RECORDS, IS AVAILABLE FOR PUBLIC REVIEW AND
COPYING FOR NONCOMMERCIAL PURPOSES.**

AS 23.30.107

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

"Injury" means accidental injury or death arising out of 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.

	Alaska Division of Worker's Compensation Offices:	Alaska Division of Labor Standards and Safety Offices:
Anchorage:	3301 Eagle Street, #304 Anchorage, AK 99503-4149 (907) 269-4980	1251 Muldoon Road, Suite 109 Anchorage, AK 99504 (907) 269-4940 or (800) 770-4940
Fairbanks:	675 Seventh Avenue, Station K Fairbanks, AK 99701-4531 (907) 451-2889	
Juneau:	1111 West 8th Street, #305 PO Box 115512 Juneau, AK 99811-5512 (907) 465-2790	1111 West 8th Street, #304 PO Box 111149 Juneau, AK 99811-1149 (907) 465-4855

EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

EMPLOYEE: All questions with an asterisk (*) must be completed

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1. Employee Name Last*		First*	Middle	Suffix
2. Mailing Address & Telephone Number*		3. Date of Birth*		4. Date of Death
City* State* Zip Code*		5. Social Security Number*		6. Gender Code <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U
Country, if outside the United States Telephone No.		7. Marital Status <input type="checkbox"/> M-Married <input type="checkbox"/> S-Separated <input type="checkbox"/> U-Unmarried <input type="checkbox"/> K-Unknown		
		8. Number of Dependents		
9. Date of Injury / Illness*	10. Time of Injury / Illness		11. Did Injury / Illness Occur on Employer's Premises? <input type="checkbox"/> Y-Yes <input type="checkbox"/> N-No	
12. Explain where injury / illness occurred		13. Employer Name*		
14. Describe Nature of Injury / Illness* (i.e., sprain, laceration, etc.)		15. Describe Part of Body Affected*		
16. Describe How the Injury / Illness Happened				
17. Injury / Illness Due to Machine/Product Failure?		18. Mechanical Guard/Safeguards Provided?		
19. List Any Machine/Substance/Object Causing Injury / Illness		20. If Machine What Part?		
21. Witness Name		Witness Business Phone Number		
22. Attending Physician Name & Contact Information		23. Hospital Name & Contact Information		
24. Initial Treatment*				
<input type="checkbox"/> 0-No Medical Treatment <input type="checkbox"/> 1-Minor On-site Remedies by Employer Medical Staff <input type="checkbox"/> 2-Minor Clinic/Hospital Remedies and Diagnostic Testing <input type="checkbox"/> 3-Emergency Evaluation, Diagnostic Testing, and Medical Procedures <input type="checkbox"/> 4-Hospitalization Greater than 24 Hours <input type="checkbox"/> 5-Future Major Medical/Lost Time Anticipated				
25. Employee Authorization to Release Medical Records*				
To all health care providers: You are authorized to provide my employer (named in box 13), 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 in box 16. 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 (box 23). 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.				
Employee Signature:				
26. If Employee Unavailable for Signature, Explain Circumstances in this Space				27. 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 employee misclassifications.

ORIGINAL TO EMPLOYER IMMEDIATELY

COPY TO EMPLOYEE

EMPLOYER: File the complete First Report of Injury (FROI), form 07-6101, with the Alaska Division of Workers' Compensation by electronic data interchange (EDI), or by mail, within 10 days of receiving this report, per AS 23.30.070(a).

Instructions for EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

TO THE EMPLOYEE

You must complete and sign this form. Keep a copy of the completed form for your records, and immediately give this form to your employer. You should notify your employer immediately, but no later than 30 days after your injury occurred or illness began.

The employer will notify their insurer, their claims administrator, and the Division of Workers' Compensation of your injury.

After obtaining medical treatment, tell your health care provider's office to submit the required "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 from 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 (contact information listed below). 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 work-related injury or illness will keep you from returning to your job at the time of injury, you may need retraining. The training benefits to which you may be entitled, and how you go about getting them, depend on your date of injury. If you are off work for 45 days, contact the division office in Anchorage to learn more about your rights for reemployment benefits. You may also refer to the Reemployment Benefits section of the "Workers' Compensation and You" brochure available at the Division's internet web page:

www.labor.state.ak.us/wc

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AS 23.30.107**

TO THE EMPLOYER

The information on this form (07-6100) and the information on form 07-6101 must be submitted to the Division of Workers' Compensation 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 or become ill while working for you.

Failure to file these reports within the required time may subject you and/or your insurer to a penalty equal to 20 percent of the amount of compensation due to the injured worker.

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