

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

**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**

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.

Alaska Division of Worker's Compensation Offices

Anchorage:
3301 Eagle Street, Suite 304
Anchorage, AK 99503-4149
(907) 269-4980

Fairbanks:
675 Seventh Avenue, Station K
Fairbanks, AK 99701-4531
(907) 451-2889

Juneau:
1111 W 8th St, Rm 305, Juneau AK 99801
PO Box 115512, Juneau AK 99811-5512
(907) 465-2790

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

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

1. Employer Name* STATE OF ALASKA 1003DNR-FOR		2. Industry (NAICS) Code Required on New Claims* See http://www.census.gov/cgi-bin/sssd/naics/naicsrch 115310	
3. Employer Contact Name & Telephone XXXXXX		4. FEIN* 451-2675 926001185	5. UI Number 588997
6. Employer Mailing Address* STATE OF ALASKA DNR-DOF 3700 AIRPORT WAY City State Zip Code FAIRBANKS AK 99709 Country, if outside the United States		7. Employer Physical Address STATE OF ALASKA DNR-DOF 3700 AIRPORT WAY City State Zip Code FAIRBANKS AK 99709 Country, if outside the United States	
8. Employee Name, Last XXXXXXXX		First XX	Middle XX
9. Employee Mailing Address* XXXXXXXX		10. Date of Birth* XX	
City State Zip Code XXX XX XX		11. Date of Death	
		12. Employee ID Type & Number* S Social Security Number XXXX 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* SELECT ONE	14. JCN / AWCB*	15. Claim Status* SELECT ONE	16. Claim Type* SELECT ONE
17. Late Reason Code DROP DOWN LIST			
18. Full Denial Reason Code DROP DOWN LIST DROP DOWN LIST DROP DOWN LIST DROP DOWN LIST DROP DOWN LIST		19. Full Denial Effective Date	
20. Denial Reason Narrative			
21. Policy Information Number N/A		Effective Date	
22. Insurer Name STATE OF ALASKA		Expiration Date	
23. Insurer FEIN 926001185		24. Insurer Type Code* S Self-Insurer	
25. Claim Administrator Name* PENSER NORTH AMERICA INC		26. Claim Administrator Primary Address* PO BOX 241148	
27. Claim Admin FEIN* 912180915	28. Claim Admin Claim No.* LEAVE BLANK		City State Zip Code ANCHORAGE AK 99524
29. Claim Admin Physical/Alternate Postal Code* 995240369			
30. Insured Name STATE OF ALASKA		31. Insured FEIN 926001185	
		32. Insured Type Code* S Self-Insured	
33. Employment Status* 8 Seasonal Worker	34. Days Worked / Week 7	35. Wage	36. Wage Period Code 02 Bi-Weekly
37. Employee Hire Date			
38. Occupation / Job Title XXX			
39. Full Wages Paid for Date of Injury Indicator DROP DOWN		40. Employer Paid Salary in Lieu of Compensation Indicator SELECT ONE	
Employer must complete either Block 41 or 42 AND Block 43: 41. Accident Site Information, if not on Employer Premises Organization Name Street City State Zip Code Country, if outside the United States		44. Date of Injury / Illness*	
42. Explain Where Injury Occurred XXX		45. Time of Injury / Illness	
43. Accident Premises Code* X Other		46. Date Employer First Knew of Injury / Illness	
44. Date of Injury / Illness*		47. Date Claim Admin Knew of Injury / Illness	
45. Time of Injury / Illness		For Blocks 48, 49 & 50 see: https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx	
46. Date Employer First Knew of Injury / Illness		48. Part(s) of Body Affected*	
47. Date Claim Admin Knew of Injury / Illness		49. Nature of Injury / Illness*	
48. Part(s) of Body Affected*		50. Cause of Injury / Illness*	
49. Nature of Injury / Illness*		51. Death Result of Injury Code DROP DOWN LIST	
50. Cause of Injury / Illness*		52. Initial Last Day Worked	
51. Death Result of Injury Code DROP DOWN LIST		53. Initial Date Disability Began	
52. Initial Last Day Worked		54. Initial Return to Work Date	
53. Initial Date Disability Began		55. Return to Work Type Code* DROP DOWN LIST	
54. Initial Return to Work Date		56. Return to Work With Same Employer? DROP DOWN	
55. Return to Work Type Code* DROP DOWN LIST		57. Physical Restrictions Indicator DROP DOWN LIST	
56. Return to Work With Same Employer? DROP DOWN		58. Signature of Authorized Employer or Representative	
57. Physical Restrictions Indicator DROP DOWN LIST		59. Title	
58. Signature of Authorized Employer or Representative		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

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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	3301 Eagle Street, #305 Anchorage, AK 99503-4149 (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

PHYSICIAN'S REPORT

ALASKA DEPARTMENT OF LABOR &
 WORKFORCE DEVELOPMENT
 Alaska Workers' Compensation Board
 P.O. Box 115512, Juneau AK 99811-5512

- INITIAL** Employee: Sections 1 & 2/Physician: Sections 3 & 4
 PROGRESS Physician: Sections 1 & 4
 TREATMENT PLAN Employee: Sections 1 & 2/ Physician: Sections 3 & 4

AWCB Case Number:

SECTION 1	1. Employee's Name (Last, First, Middle Initial)		2. Insurer Claim Number		3. Date of Injury	
	4. Address				5. Sex <input type="radio"/> Male <input type="radio"/> Female	
	City		State		Zip Code	
					Telephone	
	8. Employer				9. Insurer	
	10. Address				11. Address	
City		State		Zip Code		
				Telephone		
SECTION 2	12. Date Last Worked		13. Was Body Part Injured Before? <input type="radio"/> No <input type="radio"/> Yes If yes, when and describe:			
	14. Describe Injury and Tell How It Happened:					
	15. Have You Seen Any Other Doctor for This Injury? <input type="radio"/> No <input type="radio"/> Yes If yes, list name and address:				16. Hospitalized As Inpatient? <input type="radio"/> No <input type="radio"/> Yes Name of Hospital.	
SECTION 3	17. Your First Treatment Date		18. Describe Complaints:			
	19. Fully Describe Findings on First Examination (Specify Right or Left):					
	20. Diagnosis.					
	21. X-Rays? <input type="radio"/> No <input type="radio"/> Yes X-Ray Diagnosis:					
	22. Is Condition Work Related? <input type="radio"/> No <input type="radio"/> Yes Explain: <input type="radio"/> Undetermined (Explain).					
SECTION 4	23. Treatment Date(s) Since Last Report		24. Next Treatment Date		25. Estimate Length of Further Treatment Days Weeks Months	
	26. Medically Stable? <input type="radio"/> No <input type="radio"/> Yes		27. Date of Medical Stability		28. Injury May Permanently Preclude Return to Job at Time of Injury <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Undetermined	
	29. Will Injury Result in Permanent Impairment? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Undetermined					
	30. Impairment Rating		31. Factors on Which Rating is Based			
	32. Released for Work <input type="radio"/> No Estimate Length of Disability <input type="radio"/> 1-3 Days <input type="radio"/> 4-7 Days <input type="radio"/> 8-14 Days <input type="radio"/> 15-21 Days <input type="radio"/> 22-28 Days <input type="radio"/> More ___ Weeks ___ Months <input type="radio"/> Yes <input type="radio"/> Regular Work (Date): <input type="radio"/> Modified Work (Date): Give Limitations:					
	33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.					
	34. Describe Treatment (and/or Attach Notes)					
	35. If Case Referred to Another Physician, State Name and Address.					
	36. IRS I.D. Number					
	37. Physician's Name and Degree (Print or Type)			38. Physician's Signature		39. Report Date
40. Address		City		State		
				Zip Code		
				41. Telephone		

Worker's Compensation Injury/Illness Information
(This form to be sent to Division of Forestry Safety Officer along with Supervisor's Report)

Name _____ Date of Injury/Illness _____

Home Unit: _____

Work Location where injury/illness occurred:

- Home Office/Station
- Initial Attack
- Incident
 - Name/Number: _____
 - NWCG mnemonic or Job Title: _____

City/State: _____

Employment Status:

- Regular State Employee
 - Permanent Year-Round
 - Permanent Seasonal
 - Long-Term-Non-Perm
 - Short-Term-Non-Perm

Position Title: _____

- EFF
 - Initial Attack
 - Single Resource
 - Crew Crew Name _____
 - Type 2
 - Type 2IA
 - Type 1

Description of injury (specific body part)/illness: _____

Brief description of circumstances: _____



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

Department of Natural Resources

DIVISION OF FORESTRY/DIRECTOR'S OFFICE

3700 Airport Way
Fairbanks, AK 99709
Main: 907.451.2660
Fax: 907.451.2690

DATE: _____

To Health Care Provider

The following individual is a State of Alaska employee on an incident assignment. This letter is your authorization to provide treatment for any potential worker's compensation injuries or illness.

Name: _____

Social Security Number: _____

Please provide the necessary care to this employee and submit invoices/bills to:

Penser North America Inc.
P.O. Box 241148
Anchorage, Alaska 99524
Phone: (907) 313-7650
Fax: (907) 302-3803
katherinee@penserna.com

If you have any questions regarding State of Alaska employees, call:

Northern Region Administrative Assistance at (907) 451-2663

Your assistance is greatly appreciated.

Sincerely,

John "Chris" Maisch
State Forester

NOTICE OF EMPLOYEE RESPONSIBILITIES AND RELEASE OF MEDICAL DOCUMENTATION

FEDERAL WORKER RESPONSIBILITIES

I request medical care for a job-related injury or illness. I understand and accept my responsibilities as stated in BLM policy and on OWCP form CA-1 or CA-2. I agree to request the appropriate OWCP form(s) from the Injury Compensation Specialist prior to my medical appointment and return the completed OWCP form(s) to Financial Services immediately or on the next business day after I receive medical treatment.

I know that unless my physician certifies that I am totally disabled for any type of activity, a Restricted Duty Assignment will be made available to me within the physical restrictions set by my physician.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize any hospital, physician, Medical Service Provider or other person who has examined or attended me to furnish to the appropriate official any or all information about my injury or illness and any information which they may have concerning previous injuries or illnesses which may have a bearing on the injury as identified below.

Name (F irst, M I, L ast)	
Date of Birth (MM/DD/YYYY)	
Social Security Number	
Date of Injury (MM/DD/YYYY)	
OWCP Claim Number	

I have received a copy of:

- Notice of Employee Responsibilities and Release of Medical Documentation
- Instructions to Injured Worker
- CA-1 or CA-2, Notice of Receipt

I have read and understand the above.

----- Signature of Federal Worker/Patient	----- Date
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TO THE MEDICAL SERVICE PROVIDER

This form authorizes your office to provide information necessary to establish or manage a claim with the Department of Labor, Office of Workers' Compensation Programs (OWCP) for the federal worker who signed above. Please send chart notes, MRI, X-ray or other testing results, hospital admission, discharge and surgery records or other information regarding this injury or illness to:
BLM/Alaska Fire Service, ATTN: Injury Compensation, P.O. Box 35005, Ft. Wainwright, AK 99703.
 Send your bill for this service to OWCP with other medical bills. Injury Compensation Specialist at (907) 356-5786 for billing information.