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

EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

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

1. Employee Name Last* First* Middle Suffix

2. Mailing Address & Telephone Number*

City* State* Zip Code*

Country, if outside the United States Telephone No.

3. Date of Birth*

4. Date of Death

5. Social Security Number*

6. Gender Code ☐ F ☐ M ☐ U

7. Marital Status ☐ M-Married ☐ S-Separated ☐ U-Unmarried ☐ 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? ☐ Y-Yes ☐ 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? DROP DOWN

18. Mechanical Guard/Safeguards Provided? DROP DOWN

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*

☐ 0-No Medical Treatment
☐ 1-Minor On-site Remedies by Employer Medical Staff
☐ 2-Minor Clinic/Hospital Remedies and Diagnostic Testing
☐ 3-Emergency Evaluation, Diagnostic Testing, and Medical Procedures
☐ 4-Hospitalization Greater than 24 Hours
☐ 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

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

STATE OF ALASKA
SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Name of Injured/Damaged Equipment/Property _____

Job or Activity at Time of Accident _____ Date of Accident _____

Exact Location _____ Time _____

1. **WHAT HAPPENED?** _____

Tell what the employee was doing, how the accident occurred, and what thing directly injured the employee.

2. **WHY DID IT HAPPEN?** _____

Get all the facts by studying the job and situation involved. Use the following factors to help you identify the condition responsible.

OPERATION FACTORS TO BE CONSIDERED:

Proper Equipment	***Proper Material***	***People***
Selection	Selection	Selection
Arrangement	Placement	Placement
Use	Handling	Training
Maintenance	Use	Supervision

3. **WHAT SHOULD BE DONE?** _____

What action(s) will prevent similar accidents in the future?

4. **WHAT HAVE YOU DONE THUS FAR?** _____

Take or recommend action, depending on your authority.

5. **HOW WILL THIS IMPROVE OPERATIONS?** _____

How will it help us meet our objective – ACCIDENT PREVENTION?

6. **WHAT IS YOUR ESTIMATED COST OF THIS ACCIDENT?**

Cost of lost wage and medical expenses? ..... _____

Damage to State property or equipment? ..... _____

Damage to third parties, property and people? ..... _____

TOTAL _____

Investigated By _____ Date _____

Unit/Division/Department _____

FORMS\INVESTIG – Form 02-932

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

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 451-2675

4. FEIN*
926001185

5. UI Number
588997

6. Employer Mailing Address*
STATE OF ALASKA DNR-DOF
3700 AIRPORT WAY
City: FAIRBANKS State: AK Zip Code: 99709
Country, if outside the United States

7. Employer Physical Address
STATE OF ALASKA DNR-DOF
3700 AIRPORT WAY
City: FAIRBANKS State: AK Zip Code: 99709
Country, if outside the United States

8. Employee Name, Last: XXXXXXX First: XX Middle: XX Suffix:

9. Employee Mailing Address*
XXXXXXX
City: XXX State: XX Zip Code: XX
Country, if outside the United States

10. Date of Birth*
XX

11. Date of Death

12. Employee ID Type & Number*
S Social Security Number XXXX

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 Expiration Date

22. Insurer Name
STATE OF ALASKA

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
City: ANCHORAGE State: AK Zip Code: 99524

27. Claim Admin FEIN*
912180915

28. Claim Admin Claim No.*
LEAVE BLANK

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

42. Explain Where Injury Occurred
XXX

43. Accident Premises Code* X Other

44. Date of Injury / Illness*

45. Time of Injury / Illness

46. Date Employer First Knew of Injury / Illness

47. Date Claim Admin Knew of Injury / Illness

For Blocks 48, 49 & 50 see:
https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx

48. Part(s) of Body Affected*

49. Nature of Injury / Illness*

50. Cause of Injury / Illness*

51. Death Result of Injury Code
DROP DOWN LIST

52. Initial Last Day Worked

53. Initial Date Disability Began

54. Initial Return to Work Date

55. Return to Work Type Code*
DROP DOWN LIST

56. Return to Work With Same Employer? DROP DOWN

57. Physical Restrictions Indicator DROP DOWN LIST

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	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 ◯ Male ◯ Female	6. Social Security Number
City	State	Zip Code	Telephone		7. Date of Birth
8. Employer				9. Insurer	
10. Address				11. Address	
City	State	Zip Code	Telephone	City State Zip Code Telephone	

SECTION 2

12. Date Last Worked

13. Was Body Part Injured Before? ◯ No ◯ Yes
If yes, when and describe:

14. Describe Injury and Tell How It Happened: _____

15. Have You Seen Any Other Doctor for This Injury? ◯ No ◯ Yes
If yes, list name and address:

16. Hospitalized As Inpatient? ◯ No ◯ 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? ◯ No ◯ Yes X-Ray Diagnosis:

22. Is Condition Work Related? ◯ No ◯ Yes Explain: _____
◯ 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? ◯ No ◯ Yes	27. Date of Medical Stability	28. Injury May Permanently Preclude Return to Job at Time of Injury ◯ No ◯ Yes ◯ Undetermined	29. Will Injury Result in Permanent Impairment? ◯ No ◯ Yes ◯ Undetermined

30. Impairment Rating	31. Factors on Which Rating is Based

32. Released for Work ◯ No Estimate Length of Disability ◯ 1-3 Days ◯ 4-7 Days ◯ 8-14 Days ◯ 15-21 Days ◯ 22-28 Days ◯ More ____Weeks ____Months
◯ Yes ◯ Regular Work (Date): ◯ 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

SEE INSTRUCTIONS ON BACK

INSTRUCTIONS TO PHYSICIANS:

1. Clearly mark on reverse whether you are making an Initial, Treatment Plan, or Progress Report.
2. When making an Initial Report or Treatment Plan Report, ask employee to complete Sections 1 and 2. You should complete Sections 3 and 4.
3. When making a Progress Report, complete Items 1, 3, 6, 7, 8 and 9 of Section 1 (you may complete additional items for your own convenience) and Section 4.
4. A Treatment Plan IS REQUIRED ONLY if you treat the injured worker MORE OFTEN than provided in the following chart:

1st MONTH	2nd & 3rd MONTHS	4th & 5th MONTHS	6th THRU 12th MONTH
3 treatments per week	2 treatments per week	1 treatment per week	1 treatment per month

5. Within 14 days after each treatment, send the ORIGINAL report to the Employer. If you treat the employee more frequently than once every 14 days, you may report all treatments during a 14-day period on one form.
6. Send your billing only to the employer/insurer; the Board does not pay medical expenses.
7. If you need more space than that provided on the front of the form, use the space below.
8. You may make copies of this form.
9. Late or incomplete reporting may delay the employee's compensation payments. The employer/insurer may not be required to pay your treatment if reports are not submitted timely.

INSTRUCTIONS TO EMPLOYEE:

1. Complete Sections 1 and 2 of the Initial Report.
2. The report is NOT a substitute for your written notice of injury to your employer and the Alaska Workers' Compensation Board. If you have not already done so, immediately contact your employer and complete Items 1 through 17 of the Report of Occupational Injury or Illness (Form 07-6101).

42. Employee's Name (Last, First, Middle Initial)	43. Report Date
44. REMARKS (or Treatment Plan continued)	

Medical records in an employee's file maintained by the board are not public records subject to public inspection and copying under AS 09.25.

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 (**First, MI, Last**)	
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

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.