

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*					3. Date of Birth*			4. Date of Death	
City*			State*		Zip Code*		5. Social Security Number*		
Country, if outside the United States					Telephone No.		6. Gender Code		
							<input type="checkbox"/> F		<input type="checkbox"/> M
							<input type="checkbox"/> U		
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. Place (City/Town/Village/Camp) Where Injury / Illness Happened					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. Witness Name					Witness Business Phone Number				
18. Attending Physician Name & Contact Information					19. Hospital Name & Contact Information				
20. 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						
21. Employee Authorization to Release Medical Records*									
To all health care providers:									
<p>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.</p>									
Employee Signature:									
22. If Employee Unavailable for Signature, Explain Circumstances in this Space							23. 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
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**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		12. Employee ID Type & Number* SELECT ONE		
					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			Effective Date			Expiration Date			
22. Insurer Name					23. Insurer FEIN		24. Insurer Type Code* SELECT ONE		
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*									
30. Insured Name					31. Insured FEIN		32. Insured Type Code* SELECT ONE		
33. Employment Status* SELECT ONE		34. Days Worked / Week		35. Wage		36. Wage Period Code DROP DOWN LIST		37. Employee Hire Date	
38. Occupation / Job Title									
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					44. Date of Injury / Illness*		45. Time of Injury / Illness		
Organization Name					46. Date Employer First Knew of Injury / Illness		47. Date Claim Admin Knew of Injury / Illness		
Street					For Blocks 48, 49 & 50 see: https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx				
City			State		Zip Code		48. Part(s) of Body Affected*		49. Nature of Injury / Illness*
Country, if outside the United States					50. Cause of Injury / Illness*		51. Death Result of Injury Code DROP DOWN LIST		
42. Explain Where Injury Occurred					54. Initial Return to Work Date		55. Return to Work Type Code* DROP DOWN LIST		
43. Accident Premises Code* SELECT ONE		52. Initial Last Day Worked			53. Initial Date Disability Began		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:**

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

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

**Alaska Division of Labor Standards
and Safety Offices:**

3301 Eagle Street, #305
Anchorage, AK 99503-4149
(907) 269-4940 or
(800) 770-4940

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			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? <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

SEE INSTRUCTIONS ON BACK

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:

Table with 3 columns: Proper Equipment, Proper Material, People. Rows include Selection, Arrangement, Use, Maintenance.

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 _____



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

Department of Natural Resources

DIVISION OF FORESTRY/DIRECTOR'S OFFICE

550 W. 7th Ave, Suite 1450
Anchorage, AK 99501-3566
Main: 907.269.8463
Fax: 907.269.8931

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:

TriStar Risk Management
P.O. Box 240369
Anchorage, AK 99524-0369
Phone: (888) 538-9847
Fax: (562) 506-0330
info@tristargroup.net

If you have any questions regarding State of Alaska employees, call:
Northern Region Administrative Assistance at (907) 451-2663
Coastal Region Administrative Assistance at (907) 761-6205

Your assistance is greatly appreciated.

Sincerely,

A handwritten signature in blue ink that reads "John C. Maisch".

John "Chris" Maisch
State Forester