Alaska Department of Labor and Workforce Development
Division of Workers' Compensation
P.O. Box 115512, Juneau, AK 99811-5512

REPORT OF OCCUPATIONAL INJURY OR ILLNESS

AWCB Case Number (division use only)

EMPLOYEE: Answer ALL questions 1-20, sign, and give to your employer immediately.

1. Last Name	First Name	Initial	2. Telephone Number	3. Date of Birth	4. Sex ☐ M ☐ F	5. Social Security Number
6. Mailing Address			7. Residence Address			
6a. City	State	ZIP Code	7a. City		State	ZIP Code
8. Place (city/town/village/camp) where Injury/Occupational Illness Happened			9. Date of injury or Exposure to Disease		10. On Employer's Premises? YES ☐ NO ☐	
11. Name & Address of Attending Physician			12. Hospitalization In-Patient? YES ☐ NO ☐	13. Name of Hospital		
City	State	ZIP Code	City		State	ZIP Code
14. Describe Part(s) of Body Injured/ Nature of Occupational Illness Left ☐ Right ☐			15. Describe How the Injury or Occupational Illness Happened			

16. To all health care providers:

You are authorized to provide my employer (named in box 18), its workers' compensation liability insurance company (box 21), and its claims adjuster (box 22) information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above in box 14. 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 17a). 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/Patient's signature:

17. If employee Unavailable for Signature, explain circumstances in this space:	17a. Date Signed

EMPLOYER: Review employee answers 18-20, answer questions 21-49.

18. Employer's Name				19. Employer's Alaska Address (if different from mailing)			
20. Employer's Mailing Address (street and number)				21. Name of Insurer:			
20a. City State ZIP Code		20b. Telephone		22. Full Name and Address of Adjusting Company			
23. Date Employer First Knew of Injury	24. Date/Time (a.m./p.m.) Employee Left Work			22a. Mailing Address (street and number)			
25. Off work after Injury/Illness? YES ☐ NO ☐ 3 or more days? ☐	26. Date returned to Work	27. Death? (Y/N) Date		22b. City	State	Zip	22c. Telephone
28. Location Where Injury or Occupational Illness Happened:				29. Employee's Occupation			30. Date Hired by Employer
31. Earnings Calculated By Hr. ☐ Day ☐ Output ☐ Wk. ☐ Mo. ☐ Year ☐	32. Rate of Pay $_____ per_____	33. Days Employee Works per Week 3 or less ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐		34. Describe Scheduled Days Off			
35. Workday Began: AM ☐ PM ☐	36. Employee Paid for Day Injured or Ill? YES ☐ NO ☐	37. Federal EIN #		38. Give Details of How Injury or Illness Happened			
39. Injury/Illness Due to Machine /Product Failure? YES ☐ NO ☐	40. Mechanical Guard/Safeguards Provided? YES ☐ NO ☐	41. List any machine/substance/object causing injury				42. If machine, what part?	
43. Names and Addresses of Witnesses		44. If Injury/Illness Caused by Anyone Besides Employee, Give Name/Address					
		45. Dependents (in case of death), Names/Addresses					
46. If You Doubt Validity of Injury or Illness, State Reason:							
47. Signature of Authorized Employer Representative		48. Title				49. 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.

Distribution: Original – Workers' Compensation Division; Copy – Adjuster; Copy – Employer; Copy – Employee

State of Alaska

Department of Natural Resources

Division of Forestry

Northern Regional Office

SARAH PALIN, GOVERNOR

3700 Airport Way

Fairbanks, Alaska 99709-4699

Phone: (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 illnesses.

Name: ____

Social Security Number: ____________________________

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

Harbor Adjustment Services
1900 West Benson Blvd. Suite 101
Anchorage, AK 99517
Phone: (907) 277-1377
Fax: (907) 277-4143

If you have any questions regarding State of Alaska employees, call:
Northern Region Administrative Assistance at 907-451-2662
Coastal Region Administrative Assistance at 907-761-6205

Your assistance is greatly appreciated.

Sincerely,

John "Chris" Maisch
State Forester

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.

____

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

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

____

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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 ______________________________________

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