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).

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 xxxxx **First** xx **Middle** xx **Suffix** xx	
9. Employee Mailing Address* xxxxx; City; State; Zip Code	**10. Date of Birth*** xx / **11. Date of Death** / **12. Employee ID Type & Number*** S Social Security Number xxx; 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 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*		
30. Insured Name State of Alaska	**31. Insured FEIN** 926001185	**32. Insured Type Code*** S Self-Insured

33. Employment Status* SELECT ONE	**34. Days Worked / Week**	**35. Wage** 0	**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** Organization Name; Street; City; State; Zip Code; Country, if outside the United States	**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
42. Explain Where Injury Occurred / **43. Accident Premises Code*** SELECT ONE	

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	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

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

Form 07-6102 (Rev 01/2013)

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.

Name _____ Date of Injury/Illness _____

Home Unit: _____ (Area, Region-Warehouse, Admin, etc.)

Position Title: _____

Work Location where injury/illness occurred (if other than Home Unit; explain): _____
_____

- ☐ Home Unit Office/Station
- ☐ Initial Attack (check one): Home Area___ Out of Area___
- ☐ Project Work Site (check one): Home Area___ Out of Area___
- ☐ Incident
  - ☐ Incident Name/Number: _____
  - ☐ NWCG mnemonic or Job Title: _____

City/State: _____

Employment Status:

- ☐ Regular State Employee (check one) Fire Staff___ Resources Staff___
  - ☐ Permanent Year-Round,
  - ☐ Permanent Seasonal
  - ☐ Long-Term-Non-Perm
  - ☐ Short-Term-Non-Perm

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

Admitted to Hospital: ☐ YES ☐ NO (Admitted is remaining overnight/beyond Emergency Room).

Description of injury, body part effected, activity involved _____

_____

_____

Supervisor Name (print): _____ Signature: _____

Date: _____

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Natural Resources
DIVISION OF FORESTRY/DIRECTOR'S OFFICE
550 W 7th Ave Ste 1450
Anchorage, AK 99501-3566
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

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) 761-6217

Your assistance is greatly appreciated.

Sincerely,

Helge Eng
State Forester and Division Director

INCIDENT TIME REPORT

1. Hired At (e.g., ID-BOF)

2. Employee Common Identifier

3. Type of Employment (X One) ☐ Casual ☐ Federal ☐ Other

4. Hiring Unit Name (e.g., Ranger District)

5. Name (First, Middle, Last)

6. Hiring Unit Phone Number

7. Hiring Unit Fax Number

Column A	Column B	Column C	Column D
	Same as Column ☐ A	Same as Column ☐ A ☐ B	Same as Column ☐ A ☐ B ☐ C
8. Incident Name	8. Incident Name	8. Incident Name	8. Incident Name
9. Incident Order Number (e.g., ID-BOF-000123)	9. Incident Order Number (e.g., ID-BOF-000123)	9. Incident Order Number (e.g., ID-BOF-000123)	9. Incident Order Number (e.g., ID-BOF-000123)
10. Fire Code (e.g., B2C5) / 11. Resource Request Number (e.g., O-33)	10. Fire Code (e.g., B2C5) / 11. Resource Request Number (e.g., O-33)	10. Fire Code (e.g., B2C5) / 11. Resource Request Number (e.g., O-33)	10. Fire Code (e.g., B2C5) / 11. Resource Request Number (e.g., O-33)
12. Position Code (e.g., FFT2-T) / 13. AD Class / 14. AD Rate	12. Position Code (e.g., FFT2-T) / 13. AD Class / 14. AD Rate	12. Position Code (e.g., FFT2-T) / 13. AD Class / 14. AD Rate	12. Position Code (e.g., FFT2-T) / 13. AD Class / 14. AD Rate
15. Home/Hiring Unit Accounting Code	15. Home/Hiring Unit Accounting Code	15. Home/Hiring Unit Accounting Code	15. Home/Hiring Unit Accounting Code

Mo	Day	Start	Stop	Hours	Mo	Day	Start	Stop	Hours	Mo	Day	Start	Stop	Hours	Mo	Day	Start	Stop	Hours
Year 2022		16. Total Hours			Year 2022		16. Total Hours			Year 2022		16. Total Hours			Year 2022		16. Total Hours		

In the "hours" column, indicate "H" for hazard pay, "E" plus % for environmental differential, "T" for travel

17. Total Hours (all columns):

18.Commissary and Travel

18a. Month	18b. Day	18c. Category (e.g., commissary, meals, lodging, mileage, medical, etc.)	18d. Reimbursement	18e. Deduction	18f. Firecode
		Total	$	$	

19. Remarks

For Payment Center use only

20. Employee Signature

21. Time Officer Signature

NOTE: The above items are correct and proper for payment from available appropriations.

Department of the Interior
Department of Agriculture *(U.S. Forest Service)*

NSN 7540-01-124-7633

OPTIONAL FORM 288 (REV. 10/2015)