

**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					
<i>Employer must complete either Block 41 or 42 AND Block 43:</i>					44. Date of Injury / Illness*		45. Time of Injury / Illness		
41. Accident Site Information, if not on Employer Premises					46. Date Employer First Knew of Injury / Illness		47. Date Claim Admin Knew of Injury / Illness		
Organization Name									
Street									
City			State		Zip Code		For Blocks 48, 49 & 50 see: https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx		
Country, if outside the United States					48. Part(s) of Body Affected*		49. Nature of Injury / Illness*		
42. Explain Where Injury Occurred					50. Cause of Injury / Illness*		51. Death Result of Injury Code DROP DOWN LIST		
43. Accident Premises Code* SELECT ONE					54. Initial Return to Work Date		55. Return to Work Type Code* DROP DOWN LIST		
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:**

1251 Muldoon Road, Suite 109
Anchorage, AK 99504
(907) 269-4940 or
(800) 770-4940

1111 West 8th Street, #304
PO Box 111149
Juneau, AK 99811-1149
(907) 465-4855

EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

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

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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*		6. Gender Code <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U
Country, if outside the United States Telephone No.		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. 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*				
<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				
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

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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.

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