

## EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

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

<b>EMPLOYEE: All questions with an asterisk (*) must be completed</b>				
1. Employee Name Last*		First*	Middle	Suffix
2. Mailing Address & Telephone Number*		3. Date of Birth*		4. Date of Death
		5. Social Security Number*		6. Gender Code <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U
City*	State*	Zip Code*		
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*				
<p><b>To all health care providers:</b> 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:				
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](http://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