

REPORT OF OCCUPATIONAL INJURY OR ILLNESS

AWCB Case Number

EMPLOYEE: Answer questions 1-20, immediately mail report. Further instructions on GREEN AND YELLOW page.

1. Last Name First Name Initial		2. Telephone Number	3. Date of Birth / /	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	5. Social Security Number
5. Mailing Address City State Zip Code			7. Residence Address City State Zip Code		
6. City, Town, Village where injury occurred			9. Date & Hour of Last Exposure to Injury or Disease Date / / Hour <input type="checkbox"/> AM <input type="checkbox"/> PM		10. On Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Full Name and Address of Attending Physician City State Zip Code			12. Hospitalized as In-Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		13. Name and Address of Hospital City State Zip Code
14. Type of Injury or Illness and Part of Body Injured <input type="checkbox"/> Left <input type="checkbox"/> Right			15. Describe How the Injury or Illness Happened		
16. Employee's Signature (if not available, explain)				17. Date Signed / /	

Employee fills out and signs top part

EMPLOYER: Answer questions 18-49. Carefully follow instructions on PINK page.

18. Employer's Name City and Borough of Sitka			19. Employer's Alaska Address (if different from mailing)		
20. Employer's Mailing Address (street and number) 100 Lincoln St City State Zip Code Telephone Sitka AK 99835 907-747-1816			21. Name of Insurer ALASKA NATIONAL INSURANCE CO		
22. Full Name and Address of Adjusting Company Mailing Address (street and number) 7001 JEWEL LAKE ROAD			23. Date Employer First Knew Injury or Illness was Work Related / /		
24. Time Employee Left Work Date / / Hour <input type="checkbox"/> AM <input type="checkbox"/> PM			25. Time Lost Beyond Date of Injury or Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
26. Date Returned to Work / /			27. Death <input type="checkbox"/> Yes <input type="checkbox"/> No Date / /		
28. Location Where Injury or Illness Took Place			29. Employee's Occupation		30. Date Hired by Employer
31. Earnings Calculated By: <input type="checkbox"/> Hr <input type="checkbox"/> Day <input type="checkbox"/> Output <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Year		32. Rate of Pay \$ _____ per _____		33. Days Employee Works Per Week <input type="checkbox"/> 3 or Less <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
34. Name Scheduled Days Off		35. Workday Began <input type="checkbox"/> AM <input type="checkbox"/> PM		36. Was Employee Paid for Day of Injury or Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
37. Federal EIN Number		38. Give Details of How Injury or Illness Happened		39. Was Injury or Illness Caused by Failure of a Machine or Product? <input type="checkbox"/> Yes <input type="checkbox"/> No	
40. Were Mechanical Guards or Other Safeguards Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		41. Name Machine, Substance or Object Which Directly Injured Employee		42. If Mechanical, Specifically What Part?	
43. Names and Addresses of Witnesses			44. If the Injury or Illness Was Caused by Anyone Besides Employee, Give Name and Address		
45. Dependents (name and address in case of death)					
46. If You Doubt Validity of Injury or Illness, State Reason					
47. Signature of Authorized Employer Representative			48. Title		49. Date Signed / /

Supervisor fills out and signs bottom part

WARNING TO EMPLOYEES AND EMPLOYERS: Penalties for fraud or misleading statements. A person who knowingly makes a false or misleading statement that adversely affects another person, is guilty of deception as defined in AS 11.46.180, and may be punished as provided in AS 11.46.120-150.

See Instructions on Back of Pink and Yellow Pages

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