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).

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

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

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Division of Workers' Compensation
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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*
   City State Zip Code
   Country, if outside the United States
7. Employer Physical Address
   City State Zip Code
   Country, if outside the United States
8. Employee Name, Last First Middle Suffix
9. Employee Mailing Address*
   City State Zip Code
10. Date of Birth*
11. Date of Death
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*
    City State Zip Code
27. Claim Admin FEIN*
28. Claim Admin Claim No.*
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

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
42. Explain Where Injury Occurred
43. Accident Premises Code* SELECT ONE
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
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	3301 Eagle Street, #305 Anchorage, AK 99503-4149 (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