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| **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** |

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| **1. Employer Name\*** | **2. Industry (NAICS) Code Required on New Claims\***See <http://www.census.gov/cgi-bin/sssd/naics/naicsrch> |        |
|        |  |  |

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| --- | --- | --- |
| **3. Employer Contact Name & Telephone** | **4. FEIN\*** | **5. UI Number** |
|        |        |        |        |
| **6. Employer Mailing Address\*** | **7. Employer Physical Address** |
|        |        |
|        |        |
| **City** | **State** | **Zip Code** | **City** | **State** | **Zip Code** |
|        |     |        |        |     |        |
| **Country, if outside the United States** |        | **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**  |
|        |        |        |
|        | **12. Employee ID Type & Number\***  |
| **City** | **State** | **Zip Code** |   |        |
|        |     |        | **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\*** | **14. JCN / AWCB\*** | **15. Claim Status\*** | **16. Claim Type\*** | **17. Late Reason Code** |
|   |        |   |   |   |
| **18. Full Denial Reason Code** | **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\***  |
|        |        |   |
| **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\***  |
|        |        |   |
| **33. Employment Status\*** | **34. Days Worked / Week** | **35. Wage** | **36. Wage Period Code** | **37. Employee Hire Date** |
|   |    |        |   |        |
| **38. Occupation / Job Title** |        |
| **39. Full Wages Paid for Date of Injury Indicator** |  | **40. Employer Paid Salary in Lieu of Compensation Indicator** |  |
| ***Employer must complete either Block 41 or 42 AND Block 43:*** | **44. Date of Injury / Illness\*** | **45. Time of Injury / Illness** |
| **41. Accident Site Information, if not on Employer Premises** |        |        |
| **Organization Name** | **46. Date Employer First Knew of Injury / Illness** | **47. Date Claim Admin Knew of Injury / Illness** |
|        |  |  |
| **Street** |        |        |
|        | ***For Blocks 48, 49 & 50 see:*** [*https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx*](https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx) |
| **City** | **State** | **Zip Code** |  |
|        |     |        |  |
| **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** |
| **43. Accident Premises Code\*** |   |     |   |
| **52. Initial Last Day Worked** | **53. Initial Date Disability Began** | **54. Initial Return to Work Date** | **55. Return to Work Type Code\***  |
|        |        |        |  |
| **56. Return to Work With Same Employer?** |   | **57. Physical Restrictions Indicator** |   |
| **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.

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|  | **Alaska Division of Worker's Compensation Offices:** | **Alaska Division of Labor Standards and Safety Offices:** |
| Anchorage: | 3301 Eagle Street, #304Anchorage, AK 99503-4149(907) 269-4980 | 3301 Eagle Street, #305Anchorage, AK 99503-4149(907) 269-4940 or(800) 770-4940 |
| Fairbanks: | 675 Seventh Avenue, Station KFairbanks, AK 99701-4531(907) 451-2889 |  |
| Juneau: | 1111 West 8th Street, #305PO Box 115512Juneau, AK 99811-5512(907) 465-2790 | 1111 West 8th Street, #304PO Box 111149Juneau, AK 99811-1149(907) 465-4855 |