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

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* / 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* 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*

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: 41. Accident Site Information, if not on Employer Premises Organization Name Street City State Zip Code Country, if outside the United States	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	
42. Explain Where Injury Occurred	48. Part(s) of Body Affected*	49. Nature of Injury / Illness*
	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.

	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	1251 Muldoon Road, Suite 109 Anchorage, AK 99504 (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