HOW TO REPORT AN EMPLOYEE INJURY AND FILE A WORKERS COMPENSATION CLAIM

Employees who are injured on the job will need to complete the following steps:

Step 1: The injured employee completes a **YCHC Incident Report** as soon as possible, but no later than 24 hours after the indecent, and submits to the Compliance Officer. The Compliance Officer will submit the report to the **Attending Medical Provider** to complete.

Step 2: The injured employee completes an **Employee Report of Occupational Injury or Illness to Employer** (AK Dept of Labor & Workforce Development Form 07-6100) and submits to the Compliance Officer or their Supervisor.

Step 3: A Workers Compensation Insurance Adjuster will contact you to ask questions about your injury and will provide you with further information about your case at that time.

EVENT REPORT

YAKUTAT COMMUNITY HEALTH CENTER

This report is CONFIDENTIAL and intended to be used only for improvement of quality care and/or staff education. It will not at any time become part of a patient or personnel record.

TYPE OF INCIDENT (CHECK ALL THAT APPLY)

EVENT 1. ___Muscular skeletal injury 2. ___Body Fluid Exposure 3. ___Laceration w/out body fluid exposure 4. ___Fall 5. ___Patient Assault 6. ___Chemical Exposure 7. ___Burn 8. __Other Employee Injury 9. ___ Patient Treatment/error SAFETY 10. ___Personal article loss/damage 11. ___Patient care equipment malfunction	12. ___ Patient care equipment unavailability 13. ___Property damage/loss 14. ___Informed consent not obtained when required 14 ___Patient or patient rep threatens legal action RISK 15 ___Release of medical record and/or information without proper authorizations	16. ___Physical or sexual abuse of patient 17. ___Other (specify) _____ 18. ___Other (specify) _____ WHO WAS AFFECTED OR INVOLVED? ___Patient, ___Visitor ___employee, ___Other _____

Name of Reporter _____ (Optional, may be necessary for follow-up)

Event Date _____ Time_____ Exact location of event_____

Name of Person Affected_____

Brief Factual description of Occurrence:

_____

_____

_____

_____

Were established policies followed?

_____

_____

What policy/process change(s) do you recommend?

_____

_____

What can be done to prevent future occurrences?

_____

_____

EVENT REPORT

YAKUTAT COMMUNITY HEALTH CENTER

IMMEDIATE ACTION TAKEN:

_____

_____

_____

_____

_____ _____

Signature/Title of individual reporting the event **Date Submitted**

ATTENDING MEDICAL PROVIDER COMMENTS (if appropriate)

Significant Findings: _____

_____

_____

If employee event: do you anticipate that the employee's injury/event will result in time off? Yes___ No ___

If patient event: do you anticipate that the patient's injury/event will require further evaluation or treatment. Yes___ No ___

If so what?

_____

_____

_____

_____ _____

Medical Provider Signature **Date**

SUPERVISOR REVIEW

Has employee filled out workman's comp forms? Yes ___ No ___ NA_____

Job title of employee: _____

Recommendations to improve policy/process:

_____

_____

_____

_____ _____

Supervisor's Signature: **Date**

EVENT REPORT

YAKUTAT COMMUNITY HEALTH CENTER

SUBMIT THIS REPORT TO
THE CHIEF COMPLIANCE OFFICER

Date Received: _____

NOTIFICATIONS:

	Yes	NA		Yes	NA
Medical Director	___	___	Department of Health	___	___
Executive Health Director	___	___	OSHA Report documented	___	___
Yakutat Tribal Health Board	___	___	OSHA Report submitted	___	___
Police department	___	___	External Agency(s) _____	___	___
Guardian/parent/family member	___	___	Other_____	___	___

QUALITY IMPROVEMENT/RISK MANAGEMENT COMMITTEE REVIEW (if appropriate)
Comments:

_____

_____

_____

_____

_____

_____

_____ _____
Medical Director Signature **Date**

OTHER ACTION TAKEN:

_____

_____

_____

_____

_____ _____
Compliance Officer Signature **Date**

Event Category:
A- Unsafe Conditions
B- Near Miss
C- No Harm
D- Monitoring Required
E - Harm, treatment required
F- Hospitalization required
G- Permanent Injury
H- Near Death
I- Death
U- Undetermined

Revised 5-13-2020

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*	3. Date of Birth*	4. Date of Death
	5. Social Security Number*	6. Gender Code ☐ F ☐ M ☐ U
City* State* Zip Code*	7. Marital Status ☐ M-Married ☐ S-Separated ☐ U-Unmarried ☐ K-Unknown	
Country, if outside the United States Telephone No.	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