

**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*					7. Employer Physical Address				
City			State		Zip Code		Country, if outside the United States		
City			State		Zip Code		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		
City			State		Zip Code		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*				
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* 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					44. Date of Injury / Illness*		45. Time of Injury / Illness		
Street					46. Date Employer First Knew of Injury / Illness		47. Date Claim Admin Knew of Injury / Illness		
City			State		Zip Code		For Blocks 48, 49 & 50 see: https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx		
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 DROP DOWN LIST		
43. Accident Premises Code* SELECT ONE		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	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