

**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 <a href="http://www.census.gov/cgi-bin/sssd/naics/naicsrch">http://www.census.gov/cgi-bin/sssd/naics/naicsrch</a>				
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  Country, if outside the United States			10. Date of Birth*	11. Date of Death		
			12. Employee ID Type & Number*  Country, if outside the United States			
<b>Blocks 13 – 17 are to be completed by the Insurer / Claims Administrator submitting this report to the Division of Workers' Compensation</b>						
13. MTC Report*	14. JCN / AWCB*	15. Claim Status*	16. Claim Type*	17. Late Reason Code		
18. Policy Information Number		Effective Date	Expiration Date			
19. Insurer Name		20. Insurer FEIN	21. Insurer Type Code*			
22. Claim Administrator Name*		23. Claim Administrator Primary Address*				
24. Claim Admin FEIN*	25. Claim Admin Claim No.*		City	State	Zip Code	
26. Claim Admin Physical/Alternate Postal Code*						
27. Insured Name		28. Insured FEIN	29. Insured Type Code*			
30. Employment Status*	31. Days Worked / Week	32. Wage	33. Wage Period Code	34. Employee Hire Date		
35. Occupation / Job Title						
36. Full Wages Paid for Date of Injury Indicator			37. Employer Paid Salary in Lieu of Compensation Indicator			
<i>Employer must complete either Block 38 or 39 AND Block 40:</i> 38. Accident Site Information, if not on Employer Premises Organization Name  Street  City State Zip Code  Country, if outside the United States 39. Explain Where Injury Occurred  40. Accident Premises Code*			41. Date of Injury / Illness*		42. Time of Injury / Illness	
			43. Date Employer First Knew of Injury / Illness		44. Date Claim Admin Knew of Injury / Illness	
			<i>For Blocks 45, 46 &amp; 47 see:</i> <a href="https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx">https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx</a>			
			45. Part(s) of Body Affected*		46. Nature of Injury / Illness*	
			47. Cause of Injury / Illness*		48. Death Result of Injury Code	
49. Injury / Illness Due to Machine/Product Failure?			51. Mechanical Guard/Safeguards Provided?			
50. List Any Machine/Substance/Object Causing Injury / Illness			52. If Machine What Part?			
53. Initial Last Day Worked	54. Initial Date Disability Began		55. Initial Return to Work Date	56. Return to Work Type Code*		
57. Return to Work With Same Employer?		58. Physical Restrictions Indicator				
59. Signature of Authorized Employer or Representative			60. Title		61. 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.

	<b>Alaska Division of Worker's Compensation Offices:</b>	<b>Alaska Division of Labor Standards and Safety Offices:</b>
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