Alaska Department of Labor
Alaska Workers' Compensation Board
P.O. Box 25512, Juneau, Alaska 99802-5512

AWCB Case Number

WORKERS' COMPENSATION CLAIM

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
4. Address	5. City/Town/Village Where Injury Occurred	6. Social Security Number
City State Zip Code Telephone	7. Occupation	8. Date of Birth
9. Employer at Time of Injury	10. Insurer/Adjusting Company	
11. Address	12. Address	
City State Zip Code Telephone	City State Zip Code Telephone	

13. Describe how the injury or illness happened:

14. Part of body injured: ❐ Right ❐ Left

15. Nature of injury or illness:

16. Full name and address of attending physician(s):

17. Reason for Filing Application (be specific):

From through From through

18. This Application Amends A Prior Application Dated ______________________________

CONTINUED ON BACK

WORKERS' COMPENSATION CLAIM (Continued from Front)

19. Employee's Name (Last, First, Middle Initial)	20. Date of Injury	21. AWCB Case No.
22. Employer	23. Insurer/Adjusting Company	

24. CLAIM IS MADE FOR:

a. ❒ Temporary Total Disability From Through	e. ❒ Medical Costs (state amount requested) $	i. ❒ Penalty (state amount requested) $
From Through	f. ❒ Transportation Costs (state amount requested) $	j. ❒ Interest
From Through	g. Review of Reemployment Benefit Decision (1) ❒ Eligibility	k. ❒ Unfair or frivolous controvert (denial)
b. ❒ Temporary Partial Disability From Through	(2) ❒ Plan Review (3) ❒ Employee Cooperation	l. ❒ Attorney's Fees and Costs $
c. ❒ Permanent Total Disability From Through	(4) ❒ Other (give details and amount requested in #17 above)	m. ❒ Death Benefits
d. ❒ Permanent Partial Impairment	h. ❒ Compensation Rate (Gross Weekly Earnings) Complete to #25 below	n. ❒ Other (Give details and amount requested in #17 above)

25. COMPLETE ONLY IF YOU CHECKED 24h ABOVE (Compensation Rate). ATTACH EARNING RECORDS AS INDICATED

At the time of injury,

a. ❒ Employee was a seasonal or temporary worker. (You should attach copies of earnings documents for all work for the calendar year immediately before injury.)

b. ❒ Employee was employed less than 13 calendar weeks immediately before the injury. (You should attach copies of documents showing what Employee would have earned, not including premium or overtime pay, if employed by Employer for 13 calendar weeks immediately before injury.)

c. ❒ Employee was employed 13 calendar weeks or more immediately before the injury: (Check 1 or 2 below)

1. ❒ When injured, Employee's earnings were calculated by the : ❒ Week ❒ Month ❒ Year (You should attach copies of documents showing calculation of wages.)
2. ❒ When injured, Employee's earnings were calculated by the day, hour or output. (You should attach copies of earning records showing Employee's most favorable earnings for 13 consecutive calendar weeks within the 52 weeks immediately before injury.)

d. ❒ Employee's wages had not been set or cannot be determined. (You should attach information about the usual wage for similar services.)

e. ❒ Employee was employed by two or more employers. (You should attach copies of earning records from all employers.)

f. ❒ Employee was a minor, apprentice, or trainee in a formal training program.

g. ❒ Employee was injured working as a volunteer ambulance attendant, volunteer police officer, volunteer medical technician, or volunteer fire fighter.

h. ❒ Employee was injured before September 4, 1995. (You should attach copies of earnings documents for the two calendar years before injury and explain in #17 above if these do not fairly reflect Employee's earnings during the period of disability.)

i ❒ Employee was injured on or after September 4, 1995, is permanently totally disabled, and wages calculated by Employer don't fairly reflect earnings during the period of disability.

j. ❒ Other

26. TO BE USED IN DEATH CASES ONLY: It is claimed the deceased left the following beneficiaries:

a. Name	b. Age	c. Relationship	d. Address

27. Applicant's Name (if other than employee)			28. Telephone
29. Applicant's Address	City	State	Zip Code

FORM WILL BE RETURNED UNLESS SIGNED BELOW

30. Attorney's Name (if represented)			31. Telephone
32. Attorney's Address	City	State	Zip Code
33. Name of Individual Submitting the Form (print or type)	34. Signature		35. Date
36. Address	City	State	Zip Code

MAIL TO WORKERS' COMPENSATION BOARD

Form 07-6106 (Rev. 8/97)