AMLJIA

ALASKA MUNICIPAL LEAGUE JOINT INSURANCE ASSOCIATION

EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Employee Last Name | Employee First Name

Employee Mailing Address | City

State | Zip Code | Country | Employee Phone #

Employee Email | Employee Date of Birth

Social Security or Passport # | Number of Dependents Claimed on Taxes

Gender Code ☐ Male ☐ Female ☐ Other Marital Status ☐ Married ☐ Unmarried ☐ Separated ☐ Unknown

Date of Injury / Illness | Time of Injury / Illness | Did the Injury Occur on Employer's Premises? ☐ Yes ☐ No

Explain where the Injury / Illness Occurred

Employer Name

Describe Type of Injury (sprain, strain, laceration, etc.)

Describe Body Part(s) Affected

Body Part Side ☐ Left ☐ Right ☐ Bilateral

Describe how the injury / Illness Happened

Witness First Name | Witness Last Name | Witness Phone #

Attending Physician Name for this Injury

Hospital / Clinic Phone #

Initial Treatment

☐ No Medical Treatment ☐ Minor On-Site Remedies by Employer Medical Staff

☐ Minor Clinic/Hospital Remedies and Diagnostic Testing ☐ Emergency Evaluation, Diagnostic Testing, and Medical Procedures

☐ Hospitalization Greater than 24 Hours ☐ Future Major Medical / Lost Time Anticipated

Employee Authorization to Release Medical Records

To all health care providers:
You are authorized to provide my employer, 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. 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. 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 | Date Signed