AMLJIA

ALASKA MUNICIPAL LEAGUE JOINT INSURANCE ASSOCIATION

EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Employer Name

Employer Contact Name | Contact Phone

Employer Mailing Address | City

State | Zip Code | Country

Employee Last Name | Employee First Name

Employee Mailing Address | City

State | Zip Code | Country | Employee Phone #

Employee Email | Social Security # or Passport #

Employee Date of Birth | Employment Status | Days Worked Per Week

Wages | ☐ Per hour ☐ Per Year ☐ Other | Department or School Name

Occupation / Job Title | Employee Hire Date | Date of Injury / Illness

Time of Injury / Illness | Date Employer First Knew of Injury / Illness

Body Parts Affected

Nature of Injury

Cause of Injury / Illness

First Work Day Missed | Initial Return to Work Date

Did the employee provide a doctor's note? ☐ Yes ☐ No If yes, please send in with this form.

Did the employee return to work? ☐ Yes ☐ No Did the employee return to work with restrictions? ☐ Yes ☐ No

Did the employee return to work full duty? ☐ Yes ☐ No

Signature of Authorized Employer or Representative

Title | Date Signed