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Edmonton, AB T5J 2S5
Fax: 780-427-5863 or 1-800-661-1993
contact.centre@wcb.ab.ca

C1447A
Cognitive-Psychosocial Job Demands Analysis
Employer Version

WCB claim number

WORKER DETAILS

Worker's surname	First name and initial	
Job title	Hours per shift	Shifts per week/shift rotation
Company name		Completed by
Employer contact		Telephone number

Attach this cover page to the employer's version of the cognitive-psychosocial job demands, or copy details into section below.

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.