MAIL TO:
WORKERS' COMPENSATION INSURER

_____ - _____ - _____
Employee Social Security Number

_____
Employer UI Account Number

_____
Employer Federal ID Number

EMPLOYER REPORT
OF
INJURY/ILLNESS

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately.

PURPOSE OF REPORT: (Check all that apply)

- ☐ More than 7 days of disability
- ☐ Injury resulted in death
- ☐ Amputation or disfigurement
- ☐ Possible dispute
- ☐ Lump Sum Compromise/Settlement
- ☐ Other
- ☐ Medical only **(DO NOT mail copy to OWCA)**

1. Date of Report MM/DD/YY	2. Date / time of Injury MM/DD/YY Time ☐ AM ☐ PM	3. Normal Starting Time Day of Accident ☐ AM ☐ PM	4. If Back to Work - Give date MM/DD/YY	5. At same wage? ☐ Yes ☐ No	DO NOT WRITE IN THIS COLUMN

6. If Fatal Injury, Give Date of Death MM/DD/YY	7. Date Employer Knew of Injury MM/DD/YY	8. Date Disability began MM/DD/YY	9. Last Full Day Paid MM/DD/YY	Date Received

10. Employee Name First Middle Last	11. ☐ Male ☐ Female	12. Employee Phone # ( )	Naics:

13. Address and Zip Code	14. Parish of Injury	State-Parish

15. Date of Hire	16. Date of Birth	17. Occupation	18. Dept/Division Employed	Occupation

19. Place of Injury-Employer's Premises? ☐ Yes ☐ No	20. If No, Indicate Location-Street, City, Parish and State	Nature

21. What work activity was the employee doing when the injury occurred? (Give weight, size and shape of materials or equipment involved). Explain what employee was doing with them. Indicate if correct procedures were followed.	Part of Body
	Source
	Event
	NCCI

22. What caused injury to happen? (Describe fully the events which resulted in injury or disease. Explain what happened and how it happened. Name any objects or substances involved and explain how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)

23. Part of Body Injured and Nature of Injury or Illness (ex. left leg; multiple fractures)	24. If Occ. Disease-Give Date Diagnosed

25. Physician and Address	26. If Hospitalized, give name & address of facility

27. Employer's Name	28. Person Completing This Report-Please print

29. Employer's Address and Zip Code	30. Employer's Telephone Number ( )

31. Employer's Mailing Address-If Different From Above	32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.

33. Wage Information (optional) Employee was paid ☐ Daily ☐ Weekly ☐ Monthly ☐ Other. The average weekly wage was $ _____ per week.

LWC-WC-1007
Rev: 07/08

Insurer Name:
Phone:
Address:

Insurer's Administrator or Representative:
Phone:
Address: