LAB 500

New Hampshire

Employer's First Report of Injury

WEB-8WC –

Submission Date: _____ NHDOL# –

EMPLOYEE INFORMATION					
Employee Name (First & Last)		Gender	Hired Date		Hired in NH
ID Type - Employee ID	Date of Birth	Age	Occupation when Injured		
Employee Address	Telephone	Wages per Hour	Hrs per Day	Days per Week	Average Weekly Earnings

INJURY INFORMATION				
Injury Date / Time	Date Employer Notified of Injury	Location/Jobsite & Business Name where accident occurred		
Disability Began Date				
Claim Type	Full Wages Paid on Injury Date			
Accident Description				
Body part Injured		Cause of Injury		
Nature of Injury		Witness Name	Witness Phone	
Returned to work?	If so, what date?	If so, at what occupation?	If so, at what duty status?	
Initial Treatment			Initial Treatment Date	
Name of Treating Physician		Name of Treating Hospital	Has injured died? If so, what date	

EMPLOYER INFORMATION			
Employer Name		Employer FEIN	Industry Code
Employer Contact Name	Contact Phone Number	Employer Business Address	
Managed Care Organization			
Leased Employee? Client Company		OCIP/Wrap-Up Policy? Name of policy holder	

INSURER INFORMATION			
Insurance Carrier	Insurer Type	Policy Number	Telephone Number

SUBMITTER INFORMATION			
Submitter Name	Title of Submitter	Represents	Telephone Number

8WC (12/2014) To file this report, email to WorkersComp@dol.nh.gov, Fax Number: (603)271-6149 or
Mail to: NH Department of Labor Workers' Compensation Division 95 Pleasant St. Concord NH 03301