

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development Worker's Compensation Division

201 E. Washington Avenue, Rm. 161
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
http://www.dwd.state.wi.us/WC

IMMEDIATELY SEND A COPY OF THIS REPORT TO:

**Axley Brynelson
PO BOX 1767
MADISON WI 53701-1767**

An employer subject to the provisions of ch. 102, Wis. Stats., shall, within one day after the death of an employe due to a compensable injury, report the death to the Department of Workforce Development (DWD) and to the employer's insurance carrier, if insured. In cases of permanent disability or where temporary disability results beyond the 3-day waiting period, an insured employer shall also notify its insurance carrier of a compensable injury or illness within 7 days after the injury or beginning of a disability from occupational disease related to the employe's compensable injury.

Insurance carriers and self-insured employers must report all relevant information on this form for all compensable claims to DWD within 14 days of the date of injury.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. **See instructions for completing this form on next page.**

EMPLOYEE INFORMATION	Employee Name (First, Middle, Last)		Social Security Number			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employe Home Telephone No. ()				
	Employe Street Address				City		State	Zip Code	Occupation		
	Birthdate Mo Day Year		Date of Hire		County and State where accident or exposure occurred						
	Employer Name			WI Unemployment Insurance Account No.		Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Nature of Business (specific product)			
	Employer Mailing Address			City	State	Zip Code	Employer FEIN:				
	Name of Worker's Compensation Insurance Co. or Self-Insured Employer							Insurer FEIN:			
	Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer.							TPA FEIN:			
	Wage at Time of Injury \$		Specify per hr., wk., mo., yr., etc.		In Addition to Wages, Check Box(es) if Employee Received:		<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Tips		No. of Meals/wk No. of Days/wk Avg. Weekly Amt. \$		
	Is worker paid for overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, after how many hours of work per week?										
	Employee's Work Schedule When Injured		Start Time	Hrs. Per Day	Hrs Per Wk.	Days Per Wk.	For the 52 week period prior to the date the injury occurred, report below the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.				
Employee's Normal Full-Time Schedule for Injured's Work						No of Wks.	Gross Amount Excluding Tips \$		If Piece Work - No. of Hrs. excluding overtime		
Part-Time Employment Information		Schedule Hrs. Per Wk.	Are there other part-time workers doing the same work with the same schedule? If yes, how many?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Number of full-time employes doing the same type of work.		
Injury Date Mo Day Yr		Time of Injury AM PM		Last Day Worked Mo Day Yr		Date Employer Notified Mo Day Yr		<input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return Mo Day Yr			
Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was this a lost time or other compensable injury? <input type="checkbox"/> Yes <input type="checkbox"/> Noreport to DWD			Did injury occur because of: <input type="checkbox"/> Substance Abuse		Failure to Use <input type="checkbox"/> Safety Devices		Failure to <input type="checkbox"/> Obey Rules		
Date of Death Mo Day Yr		Name, Relationship, and Address of Closest Dependent of Deceased if Injury Caused Death									
Name of Witnesses											
Name and Address of Treating Practitioner and Hospital											
Injury Description - What happened to cause this injury or illness? Describe the employe's activities when the injury or illness occurred with details of how the event or exposure occurred. Include name(s) of other individuals involved. Specify tools, machinery, objects, chemicals, etc. that were involved in or caused the injury.											
Report Prepared By			Work Phone No. ()	Position					Date Signed		

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employe Section: Provide all requested information to identify the injured employe. If an employe has multiple dates of employment, the "Date of Hire" is the date the employe was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employe's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed.