

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development
Worker's Compensation Division
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An employer subject to the provisions of ch. 102, Wis. Stats., shall, within one day after the death of an employee 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 employee's compensable injury. Insurance carriers and self-insured employers must report all compensable claims to DWD on this form, the EDI system, or the internet format within 14 days of the date of injury.

The social security number is required under Wisconsin Statute [Privacy Law, s. 15.04(1)(m)] and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. (Please read the instructions on reverse for completing this form)

EMPLOYEE	Employee Name (First, Middle, Last):		Social Security Number:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Employee Home Telephone No: ()	
	Employee Street Address:			City:		State:	Zip Code:	Occupation:
	Birthdate: Mo. : Day : Year	Date of Hire:		County and State where accident or exposure occurred:				
EMPLOYER	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 INFORMATION	Wage at Time of Injury: Specify per hr., wk., mo., yr., etc.		In Addition to Wages, <input type="checkbox"/> Meals		No. of Meals/wk.			
	\$		Check Box(es) if <input type="checkbox"/> Room		No. of Days/wk			
			Employee Received: <input type="checkbox"/> Tips		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? _____							
	For the 52 week period prior to the week 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.							
No. of Wks:		Gross Amount Excluding Tips: \$			If Piece-Work: No. of Hrs. Excluding Overtime:			
			Start Time	Hrs. Per Day	Hrs. Per Wk.	Days Per Wk.		
Employee's Usual Work Schedule When Injured:								
Employer's Usual Full-Time Schedule For This Type of Work At Time of Employee's Injury:								
Part-Time Employment Information:		Are there other part-time workers doing the same work with the same schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?			Number of full-time employees 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 Mo Day Yr		
<input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Death: Mo Day Yr	Was this a lost time or other compensable injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury occur because of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Failure to Use Safety Devices <input type="checkbox"/> Failure to Obey Rules			
Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Name and Address of Treating Practitioner and Hospital: Case Number from the OSHA Log: _____								
Injury Description - Describe activities of employee when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved.								
What happened to cause this injury or illness? (Describe how the injury occurred)								
What was the injury or illness? (State the part of body affected and how it was affected)								
Report Prepared By:		Work Phone No: ()		Position:		Date Signed:		