

# EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development  
 Worker's Compensation Division  
 201 E. Washington Ave., Rm. C100  
 P.O. Box 7901  
 Madison, WI 53707-7901  
 Imaging Server Fax: (608) 260-2503  
 Telephone: (608) 266-1340  
 http://www.dwd.wisconsin.gov/wc  
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**Fatal Injuries:** Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.  
**Non-Fatal Injuries:** If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.  
**Electronic Reporting Requirement:** All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.  
 Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].  
 (Please read the instructions on page 2 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	Date of Hire		County and State Where Accident or Exposure Occurred?			
EMPLOYER	Employer Name <b>Workforce Development Board of SC WI</b>		WI Unemployment Ins. Acct No.	Self-Insured? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Nature of Business (Specific Product)	
	Employer Mailing Address <b>3513 Anderson Street, Suite 104</b>			City <b>Madison</b>	State <b>WI</b>	Zip Code <b>53704-</b>	Employer FEIN <b>39 - 1472579</b>
	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. Per:		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 checked="" 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 Weeks:	Gross Amount Excluding Tips: \$			If Piece-Work, No. of Hrs. Excluding Overtime:		
	Employee's Usual Work Schedule When Injured:		Start Time : <input type="checkbox"/> AM <input type="checkbox"/> PM		Hours Per Day	Hours Per Week	Days Per Week
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	Time of Injury : AM : PM	Last Day Worked	Date Employer Notified	<input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return			
Did Injury Cause Death? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Death	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 Number ( ) -		Position		Date Signed	