

# 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  
Fax: (608) 267-0394  
http://www.dwd.state.wi.us/wc/  
e-mail: DWDDWC@dwd.state.wi.us

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 provision of your social security number 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)]. **(Please read the instructions on page 2 for completing this form)**

<b>EMPLOYEE</b>	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				
<b>EMPLOYER</b>	Employer Name United Cerebral Palsy		WI Unemployment Ins. Acct No.	Self-Insured? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Nature of Business (specific product)	
	Employer Mailing Address 2801 Coho Street, Suite 300		City Madison	State WI	Zip Code 53713-	Employer FEIN -	
	Name of Worker's Compensation Insurance Co. or Self-Insured Employer Middlesex Insurance Company					Insurer FEIN -	
	Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer					TPA FEIN -	
<b>WAGE INFORMATION</b>	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 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 <b>full-time</b> 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:							
<b>Injury Description</b> - 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		

## 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.

**Employee Section:** Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee 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 employee'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. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.