This is a fill-in form. Please click on the appropriate area to enter information. Tab between fields and PRINT when completed.
A copy of the completed or partially-completed form can be SAVED.

# 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.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us


**View Instructions/Rules**

**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.

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**)

## EMPLOYEE

| Employee Name (First, Middle, Last) | Social Security Number | Sex | Employee Home Telephone No. |
|---|---|---|---|
| | - - | ☐ M ☐ F | ( ) - |

| Employee Street Address | City | State | Zip Code | Occupation |
|---|---|---|---|---|
| | | | | |

| Birthdate | Date of Hire | County and State Where Accident or Exposure Occurred? |
|---|---|---|
| | | |

## EMPLOYER

| Employer Name | WI Unemployment Ins. Acct No. | Self-Insured? | Nature of Business (Specific Product) |
|---|---|---|---|
| | | ☐ Yes ☐ No | |

| 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, Check Box(es) if Employee Received: | | |
|---|---|---|---|---|
| $ | Per: | ☐ Meals | ☐ Room | ☐ Tips |
| | | No. of Meals/wk. | No. of Days/wk | Avg. Weekly Amt. $ |

Is Worker Paid for Overtime? ☐ Yes ☐ 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: |
|---|---|---|
| | | |

| | Start Time | Hours Per Day | Hours Per Week | Days Per Week |
|---|---|---|---|---|
| Employee's Usual Work Schedule When Injured: | : ☐ AM ☐ PM | | | |
| 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? ☐ Yes ☐ No If yes, how many? | Number of **Full-Time** Employees Doing The Same Type Of Work: |
|---|---|---|
| | | |

## INJURY INFORMATION

| Injury Date | Time of Injury | Last Day Worked | Date Employer Notified | |
|---|---|---|---|---|
| | : AM : PM | | | ☐ Date Returned to Work ☐ Estimated Date of Return |

| Did Injury Cause Death? | Date of Death | Was This a Lost Time or Other Compensable Injury? | Did Injury Occur Because of: | | |
|---|---|---|---|---|---|
| ☐ Yes ☐ No | | ☐ Yes ☐ No | ☐ Substance Abuse | ☐ Failure to Use Safety Devices | ☐ Failure to Obey Rules |

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ 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 |
|---|---|---|---|
| | ( ) | | |

WKC-12-E (R. 11/2005) SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

**Print Form** **Clear Form**