

MAIL TO:
WORKERS' COMPENSATION INSURER

____ - ____ - ____
Employee Social Security Number

Employer UI Account Number

Employer Federal ID Number

**EMPLOYER REPORT
OF
INJURY/ILLNESS**

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately.

PURPOSE OF REPORT: (Check all that apply)

- More than 7 days of disability Possible dispute Medical only
 Injury resulted in death Lump Sum Compromise/Settlement **(DO NOT mail copy to OWCA)**
 Amputation or disfigurement Other

1. Date of Report MM/DD/YY	2. Date / time of Injury MM/DD/YY Time __AM __PM	3. Normal Starting Time Day of Accident __AM __PM	4. If Back to Work - Give date MM/DD/YY	5. At same wage? __Yes __No	DO NOT WRITE IN THIS COLUMN
6. If Fatal Injury, Give Date of Death MM/DD/YY		7. Date Employer Knew of Injury MM/DD/YY	8. Date Disability began MM/DD/YY	9. Last Full Day Paid MM/DD/YY	Date Received
10. Employee Name First Middle Last			11. <input type="checkbox"/> Male <input type="checkbox"/> Female	12. Employee Phone # ()	Naics:.
13. Address and Zip Code				14. Parish of Injury	State-Parish
15. Date of Hire	16. Date of Birth	17. Occupation		18. Dept/Division Employed	Occupation
19. Place of Injury-Employer's Premises ? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. If No, Indicate Location-Street, City, Parish and State			Nature
21. What work activity was the employee doing when the injury occurred? (Give weight, size and shape of materials or equipment involved). Explain what employee was doing with them. Indicate if correct procedures were followed.					Part of Body
					Source
					Event
					NCCI
22. What caused injury to happen? (Describe fully the events which resulted in injury or disease. Explain what happened and how it happened. Name any objects or substances involved and explain how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)					
23. Part of Body Injured and Nature of Injury or Illness (ex. left leg; multiple fractures)				24. If Occ. Disease-Give Date Diagnosed	
25. Physician and Address			26. If Hospitalized, give name & address of facility		
27. Employer's Name			28. Person Completing This Report - Please print		
29. Employer's Address and Zip Code			30. Employer's Telephone Number ()		
31. Employer's Mailing Address-If Different From Above			32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.		
33. Wage Information (optional) Employee was paid <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other. The average weekly wage was \$_____ per week.					

LWC-WC-1007 Insurer Name:
Rev: 07/08 Phone:
 Address:

Insurer's Administrator or Representative:
Phone:
Address:

[Download Employer's Certificate of Compliance](#)