Need to file a Workers' Compensation claim?

We make the process easy and stress free.

At Great American, we understand that filing a claim can be upsetting and stressful. That's why we give you multiple ways to report your claim.

Before reporting your claim, please have ready:

- Your policy number
- Complete and accurate information regarding the claim.

Call our reporting center

877-836-1555

Preregistration Required

To set up and gain access to our online system

Call **860-683-7078**

Once registered, report a claim online

www.Netclaim.net

So that you're best prepared to report the claim, please see the reverse side for information we may request from you.

We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it. We are available 24 hours a day, seven days a week!

Thank you for choosing Great American Insurance Group!

GREAT AMERICAN INSURANCE GROUP

Accident Information:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

Employee Information:

- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

Medical Provider Information:

- Name of clinic/doctor's office where employee was treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

After you report a claim, the Claim Reporting Center:

- Assigns your claim to an Alternative Markets Claim professional who will contact you and your employee to acknowledge the claim and initiate the process.
- Provides you with a copy of the First Report of Injury.
- Sends this report directly to the state either by mail or electronic submission, based on your state's requirements.

Alternative Markets
Claim Reporting Center:

877-836-1555

Call Preparation Guide For
Workers' Compensation Claims

Gathering complete and accurate information is the first step toward a fair and timely resolution of any claim.

When you contact the Alternative Markets Claim Reporting Center to report a claim, you will be asked a series of questions needed to complete the First Report of Injury. The items listed on the reverse side will assist with your preparation.

Once the data is collected by the Claim Reporting Center:

- Your claim will be assigned to an Alternative Markets Claim professional who will contact you to acknowledge the claim and initiate the process.
- You and your employee will receive an acknowledgment letter with the claim number and information needed to contact us directly.
- The Claim Reporting Center provides you with a copy of the First Report of Injury.
- This report will be sent directly to the state either by mail or electronic submission, based on your state's requirements.

We support employers' return to work plans, and make every effort to assist you with yours. **Please report a claim as soon as you are aware of it to 877-836-1555.**
We are here 24/7!

GREAT AMERICAN INSURANCE GROUP
Alternative Markets

Alternative Markets Claim Reporting Center:

877-836-1555

Call Preparation Guide For Workers' Compensation Claims

POLICY NUMBER: _____

ACCIDENT INFORMATION:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

EMPLOYEE INFORMATION:

- Name, physical home address, county, and home phone
- Date of birth, social security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

MEDICAL PROVIDER INFORMATION:

- Name of clinic/doctor's office where employee treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

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
- ☐ Injury resulted in death
- ☐ Amputation or disfigurement
- ☐ Possible dispute
- ☐ Lump Sum Compromise/Settlement
- ☐ Other
- ☐ Medical only **(DO NOT mail copy to OWCA)**

1.Date ofReport 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 toWork - 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. ☐Male ☐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 ? ☐Yes ☐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 ☐Daily ☐Weekly ☐Monthly ☐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

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
- ☐ Injury resulted in death
- ☐ Amputation or disfigurement
- ☐ Possible dispute
- ☐ Lump Sum Compromise/Settlement
- ☐ Other
- ☐ Medical only **(DO NOT mail copy to OWCA)**

1.Date ofReport 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 toWork - 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. ☐Male ☐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 ? ☐Yes ☐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 ☐Daily ☐Weekly ☐Monthly ☐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

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE SELF INSURANCE ☐	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM ( ) CANNOT BE DETERMINED	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year _____

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name _____

City _____ State _____

Identify the person				Describe the case		Classify the case											
						CHECK ONLY ONE box for each case based on the most serious outcome for that case:				Enter the number of days the injured or ill worker was:		Check the "injury" column or choose one type of illness:					
(A) Case No.	(B) Employee's Name	(C) Job Title (e.g., Welder)	(D) Date of injury or onset of illness (mo./day)	(E) Where the event occurred (e.g. Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from acetylene torch)	Death	Days away from work	Remained at work		Away From Work (days)	On job transfer or restriction (days)	(M) Injury	Skin Disorder	Respiratory Condition	Poisoning	Hearing Loss	All other illnesses
								Job transfer or restriction	Other record-able cases								
						(G)	(H)	(I)	(J)	(K)	(L)	(1)	(2)	(3)	(4)	(5)	(6)
					Page totals	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

Injury	Skin Disorder	Respiratory Condition	Poisoning	Hearing Loss	All other illnesses
(1)	(2)	(3)	(4)	(5)	(6)

OSHA's Form 300A (Rev. 01/2004)

Summary of Work-Related Injuries and Illnesses

Year _____

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the log. If you had no cases write "0."

Employees former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR 1904.35, in OSHA's Recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
0	0	0	0
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
0	0
(K)	(L)

Injury and Illness Types

Total number of...	(M)		(M)
(1) Injury	0	(4) Poisoning	0
(2) Skin Disorder	0	(5) Hearing Loss	0
(3) Respiratory Condition	0	(6) All Other Illnesses	0

Post this Summary page from February 1 to April 30 of the year following the year covered by the form

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment information

Your establishment name _____

Street _____

City _____ State _____ Zip _____

Industry description (e.g., Manufacture of motor truck trailers)

_____

Standard Industrial Classification (SIC), if known (e.g., SIC 3715)

____ ____ ____ ____

OR North American Industrial Classification (NAICS), if known (e.g., 336212)

____ ____ ____ ____ ____ ____

Employment information

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

_____ Company executive

_____ Title

_____ Phone

_____ Date

OSHA's Form 301
Injuries and Illnesses Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone _____ Date _____

Information about the employee

1) Full Name _____

2) Street _____

City _____ State _____ Zip _____

3) Date of birth _____

4) Date hired _____

5) ☐ Male
☐ Female

Information about the physician or other health care professional

6) Name of physician or other health care professional

_____

_____

7) If treatment was given away from the worksite, where was it given?

Facility _____

Street _____

City _____ State _____ Zip _____

8) Was employee treated in an emergency room?
☐ Yes
☐ No

9) Was employee hospitalized overnight as an in-patient?
☐ Yes
☐ No

Information about the case

10) Case number from the Log _____ *(Transfer the case number from the Log after you record the case.)*

11) Date of injury or illness _____

12) Time employee began work _____ AM/PM

13) Time of event _____ AM/PM ☐ Check if time cannot be determined

14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

15) **What happened?** Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

17) **What object or substance directly harmed the employee?** Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

18) **If the employee died, when did death occur?** Date of death

Compensacion del Trabajador

Reportando de lesiones/heridas

Usted debe reportar a su empleador cualquier enfermedad ocupacional o lesión personal que esté relacionada con el trabajo, aún y cuando usted piense que es insignificante o menor.

Enfermedades ocupacionales o muerte

En caso de enfermedad ocupacional, no todos los reclamos son elegibles a menos que el empleado haga el reclamo con su empleador dentro del siguiente año de la fecha que:

1. La enfermedad se manifiesta por si sola.
2. El empleado está desabilitado como resultado de esta enfermedad.
3. El empleado sabe o tiene rezones poderosas para creer que la enfermedad está relacionada con su ocupación.

En caso de muerte que aparece como resultado de una muerte ocupacional, no todos los reclamos son válidos solamente que el o los dependientes hagan un reclamo con el empleador del empleado muerto dentro de 1 (uno) año de:

1. La fecha de muerte.
2. La fecha que el reclamante tenga suficientes pruebas para creer que la muerte fué resultado de muerte ocupacional.

Aviso para reclamar o solicitar

En caso de lesiones o muerte causadas por accidente relacionados al trabajo o accidentes, el empleado lesionado o cualquier persona que haga un reclamando y para tener derecho a la compensación ya sea como reclamante o como el representante de la persona que está reclamando para poder tener derecho a la compensación, deberá dar aviso a su empleador dentro de los 30 días siguientes despues de la lesión. Si el aviso no es dado dentro de los siguientes 30 días, ningún pago será hecho por dicha lesión o muerte. En adición, cualquier acción fraudulenta por el empleador, empleado o cualquier otra persona con el propósito de obtener o buscar cualquier beneficio o pagos a través del Programa de Compensación de Trabajadores dicha persona está sujeta a cargos criminales al igual que a responsabilidad civil.

El aviso arriba mencionado deberá ser presentado con el empleador en la dirección que aparace en el lado derecho.

Un aviso dado no deberá ser invalidado o mantenerse invalidado por cualquier inexactitud en el tiempo, lugar, naturaleza o causa de la lesión al momento de hacer la declaración, o de otra manera, solamente si se demuestra que el empleador fué mal informado para con esto perjudicar. El fallar o faltar de notificar es posible que no perjudique al empleado si el empleador sabe del accidente o si el empleador no es perjudicado por la tardanza o por faltar de hacer la notificación.

Medicos

En caso que usted es lesionado, usted tiene el derecho de elegir al médico para su tratamiento. El empleador puede escoger otro médico y hacer arreglos para otro exámen para el cual usted será requerido para atender.

Reclamo formal

Para poder preservar sus derechos a los beneficios bajo la Ley de Compensación de los Trabajadores del estado de Louisiana, usted debe hacer un reclamo formal con la oficina administrativa del Programa de la Ley de Compensación de los Trabajadores dentro del siguiente año después del accidente si no se han hecho pagos o dentro del año después del último pago de beneficios.

Información

Si usted desea cualquier información relacionada a sus derechos y a los beneficios a los cuales usted tiene derecho descritos por la ley, usted puede llamar o escribir a la Office of Worker's Compensation Administration, PO Box 94040, Baton Rouge, Louisiana 70804-9040 o al teléfono (225) 342-7555.

Nombre y Dirección de la Compañía de Seguros

_____

_____

_____

_____

La notificación deberá ser dada ya sea llevándola personalmente o enviándola por correo certificado regresando o regresar el recibo solicitado a:

Representante del empleador

_____

_____

_____

_____

Empleador

_____

_____

_____

_____

R.S. 23:1302 manifiesta que éste aviso debe estar puesto en un lugar visible y conveniente en el negocio del empleador.

Revisado Mayo 2003

LOUISIANA WORKFORCE COMMISSION

www.laworks.net

RECORD OF OCCUPATIONAL INJURY/ILLNESS INCIDENCE RATES

INSURED
LOCATION
YEAR

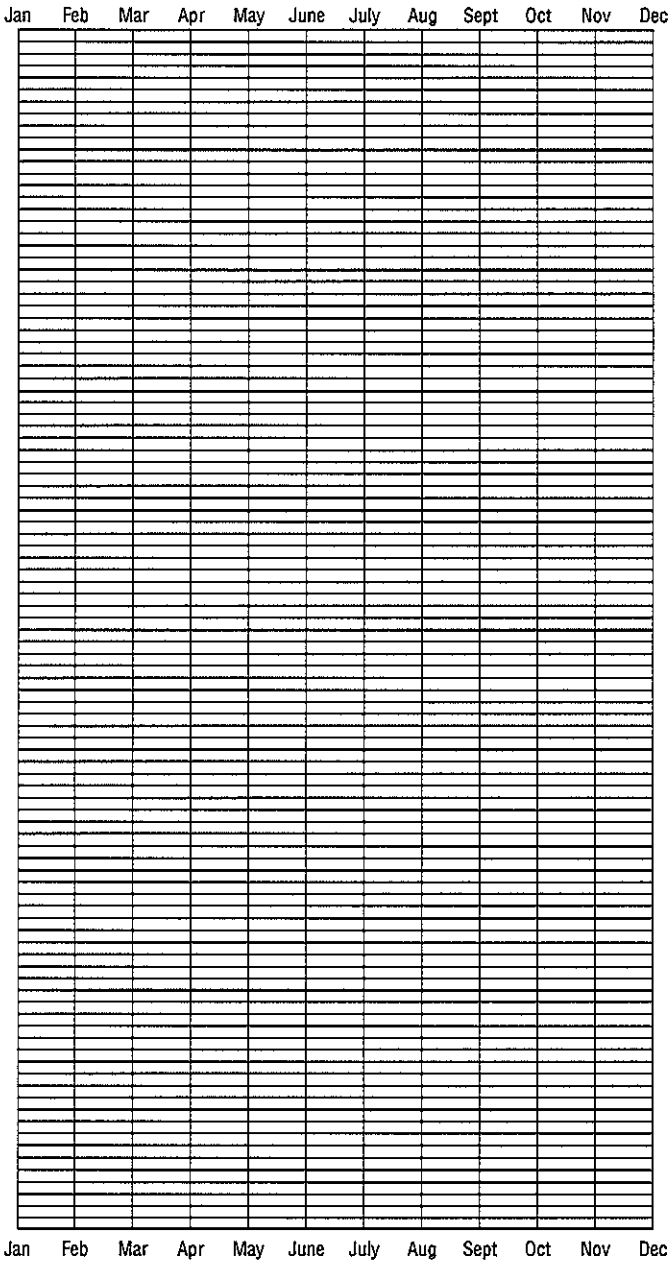
COMPARISON INCIDENCE RATES	YEAR:	
S.I.C. Code:	B.L.S.	N.S.C.
Recordable Cases		
Lost Workday Cases		
Lost Workdays		

MONTH	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
Number of Employees												
Hours Worked												
Cumulative Hours Worked												
Recordable Cases												
Cumulative Recordable Cases												
Lost Workday Cases												
Cumulative Lost Workday Cases												
Lost Workdays												
Cumulative Lost Workdays												
Monthly Incidence Rate Recordable Cases												
Cumulative Incidence Rate Recordable Cases												
Monthly Incidence Rate Lost Workday Cases												
Cumulative Incidence Rate Lost Workday Cases												
Monthly Incidence Rate Lost Workdays												
Cumulative Incidence Rate Lost Workdays												

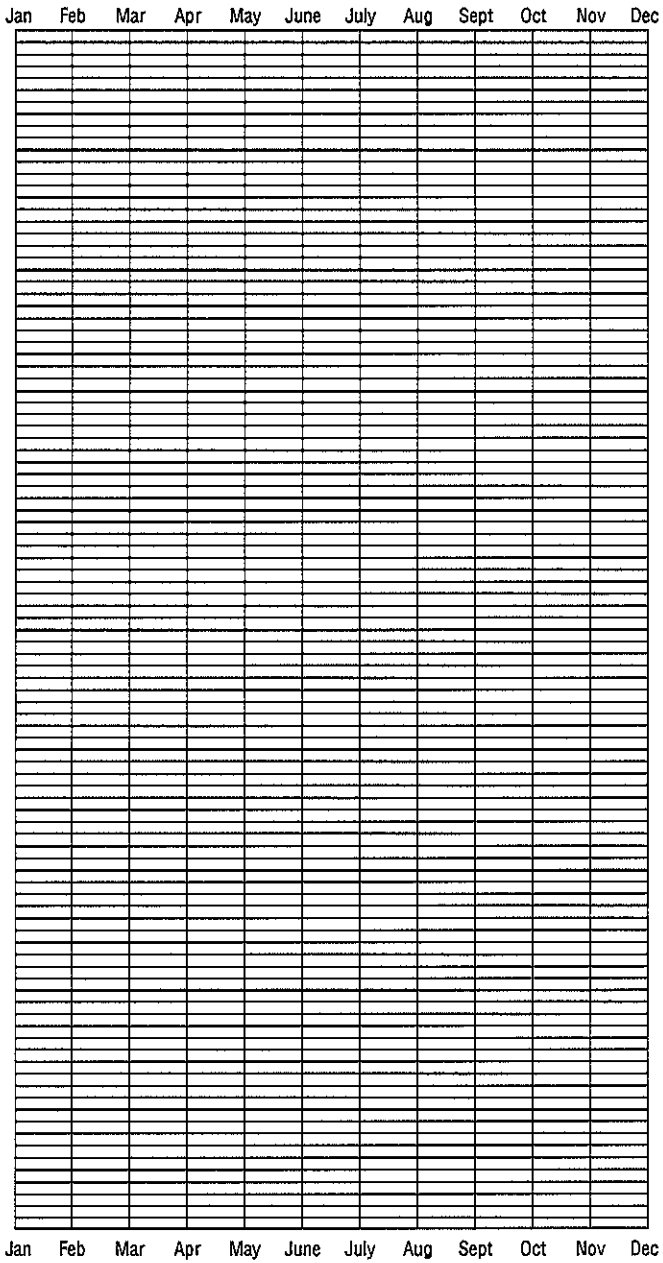
RECORD OF OCCUPATIONAL INJURY/ILLNESS INCIDENCE RATES

INSURED: _____ LOCATION: _____ YEAR OF 20____

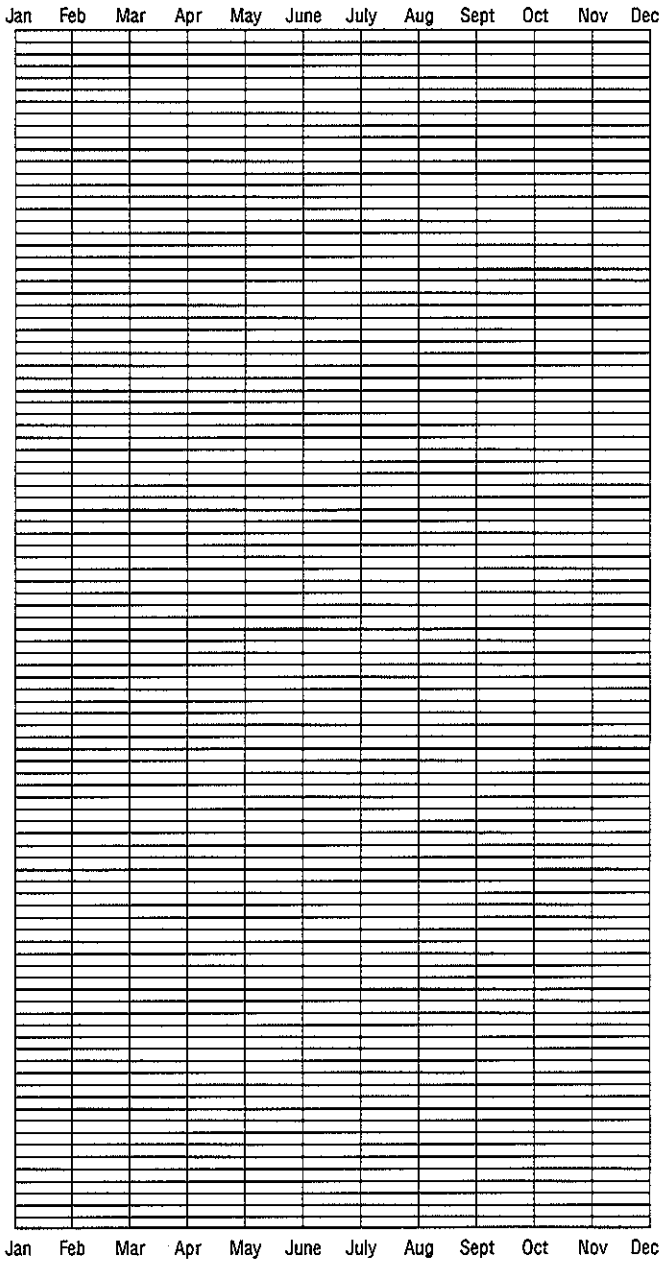
RECORDABLE CASES



LOST WORKDAY CASES



LOST WORKDAYS



KEY: _____ Monthly rate _____ B.L.S. Industry average rate

_____ Cumulative rate _____ N.S.C. Industry average rate

F.13403 (7/05)

EMPLOYEE
CERTIFICATE OF COMPLIANCE

You must submit this form to your employer's workers' compensation insurer or to your employer within 14 days of its receipt. Your workers' compensation **benefits may be suspended if you do not timely submit this Certification.** You would be entitled to all suspended benefits after this Certification is provided to your insurer, if you are otherwise eligible for benefits.

It is unlawful for you to work and receive workers' compensation disability benefits, except for supplemental earnings benefits. Supplemental earnings benefits are paid when an employee is able to work, but is unable to earn 90% or more of his pre-injury wages as a result of a job related accident. As an injured worker, you must notify your employer or insurer of the earning of any wages, changes in employment or medical status, receipt of unemployment benefits, receipt of social security benefits and receipt of retirement benefits. If you receive benefits for more than 30 days, you will be required to certify your earnings to your insurer quarterly.

It is unlawful for you to receive workers' compensation indemnity disability benefits and unemployment benefits at the same time, except for permanent partial disability benefits. Permanent partial disability benefits are paid solely for amputation or for anatomical loss of use of a body part or function. If you violate this provision, you may be fined up to $10,000, imprisoned up to 90 days, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined, imprisoned, or both, as follows:

Unlawful Benefits Paid or Claimed	Fine	Imprisonment
$10,000 or more	up to $10,000	up to 10 years, with or without hard labor
$2,500 or more but less than $10,000	up to $ 5,000	up to 5 years, with or without hard labor
less than $2,500	up to $500	up to 6 months

In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000 and may forfeit your right to receive workers' compensation benefits.

EMPLOYEE CERTIFICATION

I certify that I understand the contents of this entire document, and that I understand I am held responsible for this information. I certify my compliance with the above stated requirements regarding receipt of workers' compensation benefits.

Print Name	Signature	Social Security Number	Date

Address	City	State / Zip	( ) Phone Number

Note: Only one copy is required per case from the employee.
Please mail this form to your employer or your employer's insurer.

LWC-WC-1025.EE
REVISED 07/2008

EMPLOYEE
CERTIFICATE OF COMPLIANCE

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LWC-WC-1025.EE
REVISED 07/2008

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of $500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to $10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than $500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to $10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000.

EMPLOYER CERTIFICATION

I certify that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT) _____ Signature _____ Date _____

Company Name _____ Company Address _____

( ) _____ _____

Phone Number Insurance Policy Number

_____ _____ - - _____

Employee Name Employee Social Security Number

LWC-WC-1025.ER
REV. 7/08

EMPLOYER CERTIFICATE OF COMPLIANCE

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Preparer Name (PRINT) _____ Signature _____ Date _____

Company Name _____ Company Address _____

( ) _____ Phone Number _____ Insurance Policy Number _____

Employee Name _____ Employee Social Security Number ___-___-___

LWC-WC-1025.ER
REV. 7/08

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EMPLOYER CERTIFICATION

I certify that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)	Signature Date
Company Name	Company Address
( ) Phone Number	Insurance Policy Number
Employee Name	- - Employee Social Security Number

workers' compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1 the disease manifests itself.

2 the employee is disabled as a result of the disease.

3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

1 the date of death.

2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

_____

_____

_____

_____

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

_____

_____

_____

_____

Employer

_____

_____

_____

_____

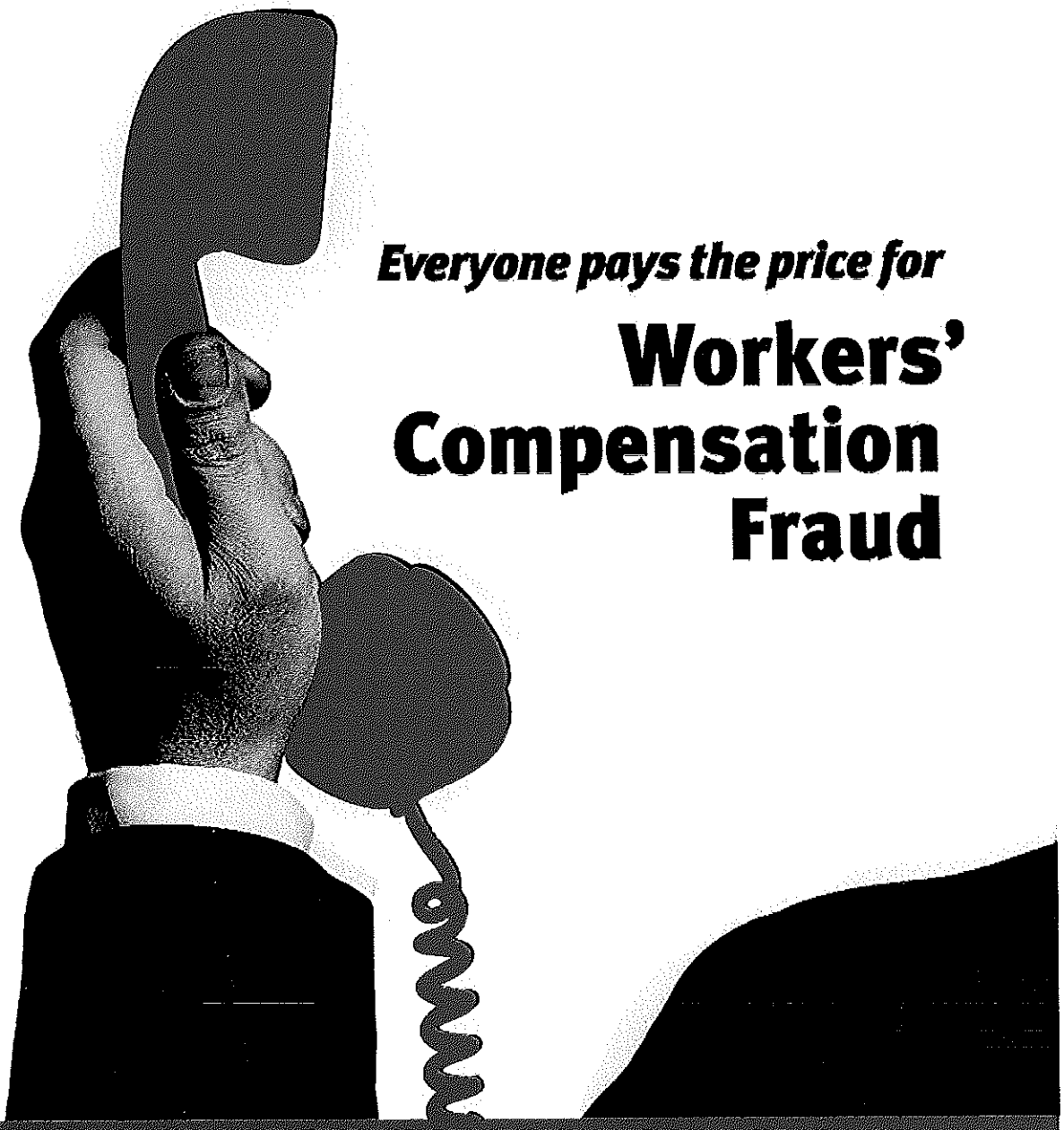
R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised 5/2003

Louisiana Workforce Commission

www.LAWORKS.net

Is someone you know **cheating** the system?



Everyone pays the price for

Workers' Compensation Fraud

Nationwide Toll-free Fraud Hotline

1.800.201.3362
(all information remains anonymous)

LOUISIANA WORKS™
DEPARTMENT OF LABOR

www.LAWORKS.net

Office 225.342.7558
Fax 225.342.1880
Email WCFraud@ldol.state.la.us