EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

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 of 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 (608) 267-0394.

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 Nam	Soc	Social Security Numb			ber Sex			Empl	ployee Home Telephone No.								
LOT	Employee Stree	Employee Street Address				City			State	State		M L F Zip Code		I (Occupation		n	
EMP													-					
	Birthdate Date of Hire					County and State Where Accident or Exposure Occurred?												
	Employer Name V				WIU	Jnemployn	nent In	s. Acct No.	Self-In □ Ye							ecific	c Product)	
	Employer Mailing Address					City			State	State Zip C		Code -			Employer FEIN -			
	Name of Worke	Co. or Se	elf-Insured							Insurer FEIN -								
	Name and Address of Third Party Administrator (TPA) Used by the Insurance Com				pany or Self-Insured Employer					TPA FEIN -		
	Wage at Time of Injury Specify per I			oer hr., w				ddition to Wages, 🛛 🗌 Meals										
5	\$											of Days/wk Weekly Amt. \$						
	Is Worker Paid for Overtime? Yes No If Yes, After How Many Hours of Work Per Week?																	
	For the 52 We and the Total V											Veeks	Work	ked in t	the Sar	ne K	ind of Work	,
	No. of Weeks	ps: \$	If Piece-Work, No. of Hrs. Ex					. Exclu	cluding Overtime:									
							Start	Time		Ho	lours Per Day Ho			Hours	ours Per Week		Days Per W	/eek
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:																		
	Employment With the Sam					-	the Same Work Number of F Same Type						ull-Time Employees Doing The Of Work:					
Z	Injury Date Time of Injur					ay Worked		ate Employe	er Notifi	ed	_		d to W					
	Did Injury Cause Death?					Nas This a Lost Ti		ne or Other	Iniurv		stimate ur Bec			Return				
	🗌 Yes 🗌 No				Co	mpensable	e Injury es 🔲	? D Substance					☐ Failure to Use ☐ Failure to Safety Devices 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 Pho			hone Nur	nber		Position							Date Signed				
	() -				-											-		
	WKC-12 (R. 10	PORT I	MMEDIA	TELY -	- DO NOT	WAIT	FOF	R ME	DICA	L RE	PORT	Г						

Department of Workforce Development

Worker's Compensation Division 201 E. Washington Ave., Rm. C100 P.O. Box 7901 Madison, WI 53707 Imaging Server Fax: (608) 260-2503 Telephone: (608) 266-1340 http://www.dwd.wisconsin.gov/wc e-mail: DWDDWC@dwd.wisconsin.gov

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.