

Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a \$5,000 fine. (Sec. 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured employee a copy of this report.

**WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY**

CASE NUMBER

**IDENTIFICATION SECTION**

NOTE: DO NOT WRITE IN SHADED BLOCKS

EMPLOYEE NAME - LAST	FIRST	M.I.	SOC SEC NO	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/>	DATE RECEIVED
ADDRESS		ADDITIONAL ADDRESS INFORMATION (C/O)			CITY	STATE	ZIP CODE
PHONE	OCCUPATION	DATE HIRED	YRS EMP'D CODE	DEPARTMENT	PAYROLL COMP CLASS CODE	OCC. CODE	
REGISTERED EMPLOYER		DBA					
ADDRESS				CITY	STATE	ZIP CODE	
PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED	DATE OF INJURY/ILLNESS	PREFAB	DOL NUMBER	DBA	
		MM / DD / YY	MM / DD / YY	<input type="checkbox"/> WC-2 <input type="checkbox"/> WC-5			

**DETAIL OF INJURY / ILLNESS**

TIME OF INJURY/ILLNESS	TIME OF I/I CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS	CITY	STATE	ON EMPLOYER'S PREMISES <input type="checkbox"/> YES <input type="checkbox"/> NO	INDUSTRIAL CODE
___ AM ___ PM						
HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary)				TIME WORKSHIFT BEGAN	SOURCE OF INJURY	EVENT
				___ AM ___ PM		
WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using)				TASK	ACTIVITY	ACCIDENT FACTOR
				AOS		
OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin. In cases of strains, the thing he was lifting, pulling, etc.)						
DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED				DISFIGUREMENT	NATURE OF INJURY	PART OF BODY
				<input type="checkbox"/> YES <input type="checkbox"/> NO		
				BURNS	<input type="checkbox"/> YES <input type="checkbox"/> NO	

**TIME LOST INFORMATION**

DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISHED MEALS OR LODGING	AVG WKLY WAGE	IF EMPLOYEE IS BACK TO WORK GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS	IF EMPLOYEE DIED GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS WKED / WK	WEIGHING FACTOR
MM / DD / YY	<input type="checkbox"/> YES <input type="checkbox"/> NO		MM / DD / YY	<input type="checkbox"/> YES <input type="checkbox"/> NO	MM / DD / YY				
GIVE NAME AND ADDRESS OF SURVIVORS ON BACK									

**TREATMENT**

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN	ADDRESS	PHYSICIANS I.D. CODE
NAME OF MEDICAL FACILITY	ADDRESS	INPATIENT OVERNIGHT? <input type="checkbox"/> YES <input type="checkbox"/> NO EMERGENCY ROOM ONLY? <input type="checkbox"/>
CARRIER I.D.		

**INSURANCE**

NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY	IF LIABILITY DENIED - WHY?	IS LIABILITY DENIED? <input type="checkbox"/> YES <input type="checkbox"/> NO
POLICY NO.	POLICY PERIOD	ADJUSTER NAME	CARRIER CASE NO.
		ADJUSTER I.D.	MEDICAL DEDUCTIBLE

**SIGNATURE**

TITLE	DATE
	MM / DD / YY