Instructions For Completing The Employer Report Of Injury/Illness (LWC-WC-1007)

Items with an asterisk are required and must be completed or your form will be returned. This form is due within 10 days of your knowledge of an incident which results in death or time lost from work in excess of 7 days. It is also due when you receive notice of a disputed claim (LWC-WC-1008) or when you have negotiated a lump sum settlement (LWC-WC-1011). It may also be requested at other times by the OWCA. It is the *employer's* responsibility to complete this form and a copy must be provided to the employee. Failure to submit this form when required may result in a fine of up to $500.00 being assessed against the employer. The employer's insurance carrier might also require this form. It is also presently accepted by OSHA in lieu of their form OSHA 101.

Upper Right Corner:

- *** EMPLOYEE SOCIAL SECURITY NUMBER** - Enter the injured employee's social security number. This is a nine digit number and you should enter it as three digits, a dash, two digits, a dash, then four digits.
- *** EMPLOYER U.I. ACCOUNT NUMBER** - This is a six digit number assigned by the Louisiana Workforce Commission for the purpose of reporting unemployment insurance taxes.
- *** EMPLOYER FEDERAL IDENTIFICATION NUMBER** - This should be a nine digit number. This is the number used when reporting federal withholding and FICA taxes. You may provide this number or the U.I. account number. One or the other is *required* to process your form.
- **PURPOSE OF REPORT** - Check all that apply. Remember if either the employee or employer thinks the case is work-related this form is due. Check Possible Dispute to indicate there is a possible disagreement.

BODY OF THE REPORT:

- **ITEM 1 - DATE OF THE REPORT** - This should be in MM/DD/YY format with slashes between the month, date and year. This field represents the date that the report is being typed or completed.
- *** ITEM 2 - DATE OF INJURY** - The date of the injury should be entered here. Also, enter the time of the injury and check A.M.or P.M.
- **ITEM 3 - NORMAL STARTING TIME** - Again, this should be entered in standard 12 hour format, such that one o'clock in the afternoon would be entered 1:00 and the P.M. box checked.
- *** ITEM 4 - IF EMPLOYEE BACK TO WORK, GIVE DATE** - If the employee has returned to work since the injury and has continued to work, the date of the return should be entered in block 4. If the employee has not returned to work, then you should enter "still out" in this blank.
- **ITEM 5 - AT SAME WAGE** - If the employee has returned, then Item 5 should be answered. If the employee is earning as much or more than the wages at the time of the injury, the "Yes" block should be checked. If the employee is earning less than the earnings at the time of injury, the "No" block should be checked.

- **ITEM 6 - IF FATAL INJURY, GIVE DATE OF DEATH** - If the employee died as a result of the accident or occurrence at work, then the date of death should be entered in the MM/DD/YY format. This is required if incident resulted in death.

- **ITEM 7 - THE DATE EMPLOYER KNEW OF INJURY** - The employer knew of the injury of illness when it was brought to the employer's attention. The employer could be any supervisor or agent of the employer. The fact that this report is being typed indicates that the employer knew of the incident at some time. Enter the earliest date in MM/DD/YY format that the employer knew of the injury or illness.

- *** ITEM 8 - DATE DISABILITY BEGAN** - Sometimes the employee does not become disabled until after the incident occurred. At other times the disability is immediate. In this block place the first date that the employee lost time from work as a result of the injury or illness. It should be entered in MM/DD/YY format.

- **ITEM 9 - LAST FULL DAY PAID DATE** - Enter the last day the employee was paid in full. If the disability began as a result of the employee leaving work at the end of the work day, then the last full day paid would be the day the injury occurred. If the employee was injured early in the work day and was not paid for the full day, then the last full day paid would be the prior work day. Use MM/DD/YY format.

- *** ITEM 10 - EMPLOYEE: FIRST, MIDDLE, LAST** - Enter the employee's name in the form of first name, middle name or initial, last name.

- *** ITEM 11 - MALE, FEMALE** - Check the box indicating the gender of the injured employee.

- **ITEM 12 - EMPLOYEE TELEPHONE NUMBER (Include Area Code)** - Enter the employee's telephone number including the area code.

- *** ITEM 13 - COMPLETE ADDRESS** - This should be the mailing address of the employee and should include the street address, city, parish, state and zip code. Parish of employee's residence is *required*.

- *** ITEM 14 - PARISH OF INJURY** - Enter the name of the parish in which the injury/illness occurred.

- **ITEM 15 - DATE OF HIRE** - Enter date employee was hired by you. If break in employment greater than 6 months, enter the re-hire date.

- *** ITEM 16 - DATE OF BIRTH** - Enter the employee's date of birth.

- *** ITEM 17 - OCCUPATION** - Give a clear description of the employee's occupation. Try to avoid jargon that would be difficult to understand. Do not abbreviate with single letters; such as F.S.W. Instead, put Food Service Worker.

- **ITEM 18 - DEPARTMENT OR DIVISION REGULARLY EMPLOYED** - The department or division regularly employed will help those investigating the accident in large plants to find the place where the accident occurred and the people who may know about the accident.

- **ITEM 19 - PLACE OF INJURY -- EMPLOYER'S PREMISES: YES OR NO** - Indicate whether the injury occurred on the employer's premises. A "Yes" indicates that the injury took place on the employer's premises.

- **ITEM 20 - IF "NO"- GIVE CITY & STATE** - If the "No" block was checked, list the exact location of the injury including city, and state.

- *** ITEM 21 - WHAT WORK ACTIVITY WAS THE EMPLOYEE DOING?** - Describe events fully giving the weight, size and shape of materials or equipment involved. Indicate if employee was following correct work procedures. Specify if this is an occupational injury or illness.

  Example 1 - Employee injured while lifting numerous 30 lb. boxes into truck at loading dock. Dollies are provided for this task but employee refused to use them.

  Example 2 - Employee injured while climbing a 10 foot ladder and carrying 20 pounds of roofing materials and cutting tools.

  Example 3 - Employee became ill after spraying insecticide from a hand sprayer. Respirator was provided but not used.

- **ITEM 22 - WHAT CAUSED INCIDENT TO HAPPEN?** - Describe fully the events which resulted in injury or disease. Tell *what happened* and *how it happened*. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to injury or illness. This should be a narrative explaining specifically how the incident took place.

  Example 1 - Employee complained of back pain after lifting boxes for 1 week (approximately 50 boxes per day).

  Example 2 - Ladder slipped on wet ground and employee fell 10 feet.

  Example 3 - Gasket on sprayer broke and employee's eyes and mouth were filled with Demeton.

- *** ITEM 23 - PART OF BODY AND NATURE OF INJURY/ILLNESS** - This blank identifies the part(s) of body involved and the nature of the injury and illness to that body part(s). Be sure to include all parts of body affected.

  Example 1 - Sprain to lower back, strain to upper back.

  Example 2 - Fractured right ankle, fractured right femur, amputated right index finger at 2nd joint, sustained multiple bruises and contusions over entire body, strained lower back.

  Example 3 - Redness and itching of the eyes, vomiting, abdominal cramps, difficulty breathing and convulsions.

- **ITEM 24 - IF OCCUPATIONAL DISEASE - GIVE DATE DIAGNOSED** - Complete this block for all occupational disease cases by entering the date a physician diagnosed the disease/illness as occupational.

- **ITEM 25 - PHYSICIAN AND ADDRESS** - List the physician who treated the employee initially. Give their address.

- **ITEM 26 - HOSPITAL NAME AND ADDRESS** - If admitted for treatment, give the name and address of hospital.

- *** ITEM 27 - EMPLOYER NAME** - Enter the name of the employer as it is carried on the employer's insurance policy.

- *** ITEM 28 - PERSON COMPLETING THIS REPORT** - Enter your name.

- *** ITEM 29 - EMPLOYER ADDRESS** - Enter the address of the employer including the street address, city, state and zip.

- *** ITEM 30 - EMPLOYER'S TELEPHONE NUMBER** - Enter the telephone number at work where you can be reached. If there is an extension include that as well as the area code.

- **ITEM 31- EMPLOYER'S MAILING ADDRESS - IF DIFFERENT FROM ABOVE** - If the employer has a mailing address different from the address listed in Item 29 enter it in this block.

- **ITEM 32 - NATURE OF BUSINESS** - Enter the nature of the business of the employer. This should be as specific as possible. For example use auto part manufacturing instead of part manufacturing, or single family residential construction instead of construction.

- **ITEM 33 - WAGE INFORMATION** - This is optional. You may indicate how employee was paid and the average weekly wage.

- **NAME OF WORKER'S COMPENSATION INSURER** - Enter Employer's Workers' Compensation carrier's name and address. If self-insured write "self-insured". If a member of a group self insured plan, name that group and *not* the adjusting company or claims administrator. Give the phone number and area code of their claims department.

- **Employer Certificate of Compliance** - LWC-WC-1025.ER or Employer Certificate of Compliance should be submitted with the first report of injury.