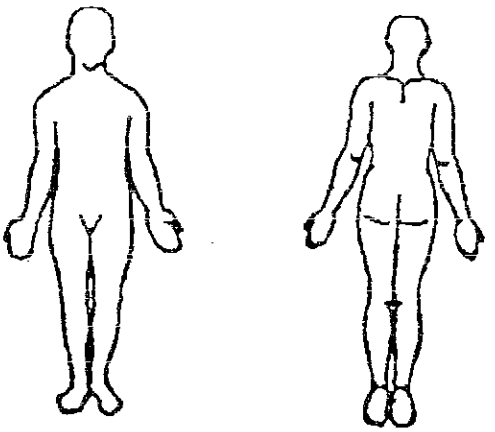
EMPLOYEE'S INJURY REPORT

This form must be completed in detail and signed by the injured employee.

Your Name	Company You Work For	
Social Security Number	City	Dept
Your Address(Street, City,State & Zip)	Supervisor's Name	
Phone Number Where You Can Be Reached	Job Title at Time of Injury	
Date of Hire	How Long In Current Position Yrs Months	

Details of the Injury

Date of Injury	Time of Injury AM/PM	Date you first Lost Time
Where in the workplace did your injury occur?		
How did your injury happen? Describe in detail		
What safety equipment was provided to you at the time of the accident?		
Was the cause of your injury due to human or machine error _____Human _____Machine Error		
In your opinion, what was the cause of your injury?		
What safety measures do you think can be taken to prevent an injury of the type in the future?		

When did you attend your last safety meeting? List as many as you can of the topics from that meeting.
When were you first aware of this injury?
When did you first notify your supervisor of your injury?
What part of your body is injured?
On the diagram provided below, please circle the part(s) of your body where you are experiencing pain due to this injury 
Did anyone witness your accident? List the names of any witnesses.
Was anyone else injured in this incident? List the names of any other injured people.
In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.

I certify that the information containged in this report is true and correct.
I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.
I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company.

Employee's Printed Name Employee's Signature Date

SUPERVISOR'S INVESTIGATION OF ACCIDENT

This form must be completed for all employee injuries. Please be as thorough as possible. This information will be used to prevent future injuries of this type.

Name of injured employee	Date of injury	Time of injury AM/PM	
Date injured employee stopped working	Was injured employee doing his/her regular job? Yes No	Shift Start&End times	
Employee's job title when injured?	How long on this type of work?	Yrs	Mo
Describe injury or illness in detail, including part of body affected, type of injury and treatment received.			
Describe the accident, include events leading up the the accident. Please be as detailed as possible.			
Describe fully any conditions which in your opinion may have contributed to this accident. Describe any human error or machine error involved.			
If machine error, has the condition been corrected? If "No", when will the condition be corrected?			
What safety equipment was provided to the employee at the time of the accident? Was it being properly used at the time of the injury?			
Were there any witnesses to this injury? If so, please identify.			
When were you first notified of this injury?			
What action has been taken to prevent a similar accident/injury?			
Is there any additional information that you feel may be beneficial to the Claims Administrator?			
Supervisor's Printed Name	Supervisor's Signature	Department	Date

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

An employer subject to the provisions of ch. 102, Wis. Stats., shall, within one day after the death of an employee due to a compensable injury, report the death to the Department of Workforce Development (DWD) and to the employer's insurance carrier, if insured. In cases of permanent disability or where temporary disability results beyond the 3-day waiting period, an insured employer shall also notify its insurance carrier of a compensable injury or illness within 7 days after the injury or beginning of a disability from occupational disease related to the employee's compensable injury.
Insurance carriers and self-insured employers must report all compensable claims to DWD on this form, the EDI system, or the internet format within 14 days of the date of injury.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

The social security number is required under Wisconsin Statute [Privacy Law, s. 15.04(1)(m)] and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. **(Please read the instructions on reverse for completing this form)**

EMPLOYEE

Employee Name (First, Middle, Last):	Social Security Number:	Sex: ☐ M ☐ F	Employee Home Telephone No: ( )	
Employee Street Address:	City:	State:	Zip Code:	Occupation:
Birthdate: Mo. Day Year	Date of Hire:	County and State where accident or exposure occurred:		

EMPLOYER

Employer Name:	WI Unemployment Insurance Account No:	Self-Insured? ☐ Yes ☐ No	Nature of Business (specific product):	
Employer Mailing Address:	City:	State:	Zip Code:	Employer FEIN:
Name of Worker's Compensation Insurance Co. or Self-Insured Employer:				Insurer FEIN:
Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer:				TPA FEIN:

WAGE INFORMATION

Wage at Time of Injury: Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received: ☐ Meals ☐ Room ☐ Tips	No. of Meals/wk. _____ No. of Days/wk _____ Avg. Weekly Amt. $_____
$		

Is worker paid for overtime? ☐ Yes ☐ No If yes, after how many hours of work per week? _____

For the 52 week period prior to the week the injury occurred, report below the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.

No. of Wks:	Gross Amount Excluding Tips: $	If Piece-Work: No. of Hrs. Excluding Overtime:

	Start Time	Hrs. Per Day	Hrs. Per Wk.	Days Per Wk.
Employee's Usual Work Schedule When Injured:				
Employer's Usual Full-Time Schedule For This Type of Work At Time of Employee's Injury:				

Part-Time Employment Information:	Are there other part-time workers doing the same work with the same schedule? ☐ Yes ☐ No If yes, how many?	Number of **full-time** employees doing the same type of work:

INJURY INFORMATION

Injury Date: Mo Day Yr	Time of Injury: ____ AM ____ PM	Last Day Worked: Mo Day Yr	Date Employer Notified Mo Day Yr	☐ Date Returned to Work Mo Day Yr ☐ Estimated Date of Return

Did injury cause death? ☐ Yes ☐ No	Date of Death: Mo Day Yr	Was this a lost time or other compensable injury? ☐ Yes ☐ No	Did injury occur because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to 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 Phone No: ( )	Position:	Date Signed:

WKC-12 (R. 10/2001) **SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT**