

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 MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	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/ILLNES 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	INDUSTRIAL CODE	
____ AM ____ PM							<input type="checkbox"/> YES <input type="checkbox"/> NO		
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 employee's skin. In cases of strains, the object employee 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	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
						BURNS			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			

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					PHYSICIAN I.D. CODE		
NAME OF MEDICAL FACILITY		ADDRESS					INPATIENT OVERNIGHT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
							EMERGENCY ROOM ONLY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
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.
SIGNATURE		ADJUSTER I.D.	MEDICAL DEDUCTIBLE
		TITLE	DATE
			MM / DD / YY