

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 MM / DD / YY		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	MARITAL STATUS MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/>	DATE RECEIVED MM / DD / YY		
ADDRESS			ADDITIONAL ADDRESS INFORMATION (C/O)			CITY		STATE	ZIP CODE		
PHONE	OCCUPATION	DATE HIRED MM / DD / YY	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 MM / DD / YY	DATE OF INJURY/ILLNESS MM / DD / YY	PREFAB <input type="checkbox"/> WC-2 <input type="checkbox"/> WC-5		DOL NUMBER		DBA		

DETAIL OF INJURY / ILLNESS												
TIME OF INJURY/ILLNESS ____ AM ____ PM		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		
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 ____ AM ____ PM	SOURCE OF INJURY		EVENT		
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 <input type="checkbox"/> YES <input type="checkbox"/> NO		BURNS <input type="checkbox"/> YES <input type="checkbox"/> NO		NATURE OF INJURY	PART OF BODY

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

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	

INSURANCE				CARRIER I.D.	
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	