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.

PRINT

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

RESET

NOTE: DO NOT WRITE IN SHADED BLOCKS

CASE NUMBER

IDENTIFICATION SECTION

EMPLOYEE NAME - LAST	FIRST	M.I.	SOC SEC NO	DATE OF BIRTH MM / DD / YY	SEX ☐ MALE FEMALE ☐	MARITAL STATUS MARRIED ☐ ☐ SINGLE	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/ILLNESS REPORTED MM / DD / YY	DATE OF INJURY/ILLNESS MM / DD / YY	PREFAB ☐ WC-2 ☐ 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 ☐ YES ☐ 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 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 _____

	YES	NO
DISFIGUREMENT	☐	☐
BURNS	☐	☐

NATURE OF INJURY

PART OF BODY

TIME LOST INFORMATION

DATE DISABILITY BEGAN MM / DD / YY	WAS EMPLOYEE FURNISHED MEALS OR LODGING ☐ YES ☐ 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 ☐ YES ☐ NO	IF EMPLOYEE DIED GIVE DATE MM / DD / YY	HOURLY WAGE	MONTHLY SALARY	HRS WKED / WK	WEIGHING FACTOR

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? YES ☐ NO ☐ EMERGENCY ROOM ONLY? YES ☐ NO ☐

INSURANCE

CARRIER I.D. 1299

NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY	IF LIABILITY DENIED – WHY?	IS LIABILITY DENIED? ☐ YES ☐ NO
HEMIC			

POLICY NO.	POLICY PERIOD	ADJUSTER NAME	CARRIER CASE NO.

ADJUSTER I.D. 3208

MEDICAL DEDUCTIBLE

SIGNATURE

	TITLE	DATE Feb 6, 2009 MM / DD / YY

(REV. NOV/01)