

MAIL TO:  
WORKERS' COMPENSATION INSURER

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Employee Social Security Number  
\_\_\_\_\_  
Employer UI Account Number  
\_\_\_\_\_  
Employer Federal ID Number

## EMPLOYER REPORT OF INJURY/ILLNESS

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately. **Forms for cases resulting in more than 7 days of disability or death** are to be sent to the OWCA **by the 10<sup>th</sup> day after the injury** or as requested by OWCA.

**PURPOSE OF REPORT:** (Check all that apply)

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> More than 7 days of disability | <input type="checkbox"/> Possible dispute               | <input type="checkbox"/> Medical only |
| <input type="checkbox"/> Injury resulted in death       | <input type="checkbox"/> Lump Sum Compromise/Settlement | (DO NOT mail copy to OWCA)            |
| <input type="checkbox"/> Amputation or disfigurement    | <input type="checkbox"/> Other                          |                                       |

1. Date of Report MM/DD/YY	2. Date / Time of injury: MM/DD/YY Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	3. Normal Starting Time Day of Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM	4. If Back to Work Give date: MM/DD/YY	5. At same wage? <input type="checkbox"/> yes <input type="checkbox"/> no	DO NOT WRITE IN THIS COLUMN
6. If Fatal injury, give Date of Death: MM/DD/YY	7. Date Employer Knew of Injury: MM/DD/YY	8. Date Disability Began: MM/DD/YY	9. Last Full Day Paid MM/DD/YY	Date Received:	
10. Employee Name: First Middle Last			11. <input type="checkbox"/> Male <input type="checkbox"/> Female	12. Employee Phone # ( ) -	S.I.C
13. Address and Zip Code LA,			14. Parish of Injury	State-Parish	
15. Date of Hire	16. Date of Birth:	17. Occupation:	18. Dept/Division Employed:	Occupation	
19. Place of Injury-Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. If No, Indicate Location-Street, City Parish and State			Nature
21. What work activity was the employee doing when the incident occurred? (Give weight, size and shape of materials or equipment Involved. Tell what he was doing with them. Indicate if correct procedures were followed.)					Part of Body
					Source
					Event
					NCCI
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 to or contributed to this injury or illness.)					
23. Part of Body Injured and Nature of Injury or Illness (ex. Left leg: multiple fractures)				24. If Occ Disease-Give Date Diagnosed:	
25. Physician and Address			26. If hospitalized, give name & address of facility		
27. Employer's Name			28. Person Completing This Report – Please Print		
29. Employer's Address and Zip code			30. Employer's Telephone Number ( ) -		
31. Employers Mailing Address – If Different From Above			32. Nature of Business – Type of Mfg., Trade, Construction, Service, etc.		
33. Wage Information (optional): Employee was paid <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other. The average weekly wage was \$ per week.					

LDOL-WC-1007 NAME OF WORKERS' COMPENSATION INSURER  
REV. 10/98 PHONE NUMBER (225) 389-5822

**LUBA WORKERS' COMP**  
P.O. BOX 98082  
BATON ROUGE, LOUISIANA 70898-9082