

STATE OF LOUISIANA  
Office of Workers' Compensation Administration  
P.O. Box 94040  
Baton Rouge, LA 70804-9040  
(504) 342-7555  
Toll Free 1-800-824-4592

**EMPLOYER'S REPORT**  
OF  
**OCCUPATIONAL INJURY  
OR DISEASE**

Injured's Social Security Number
Employer's UI Reporting Number
Employer's Federal ID Number
Insurance Policy Number

DATES	1. Date of Report MM/DD/YY	2. Date of Injury and Time MM/DD/YY Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	3. Normal Starting Time Day of Accident Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	4. If Employee Back to Work Give Date: MM/DD/YY	5. At Same Wage? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>DO NOT WRITE IN THIS COLUMN</b>
	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-Date MM/DD/YY	Date Received	
EMPLOYEE	10. Employee: First Middle Last			11. <input type="checkbox"/> Male <input type="checkbox"/> Female	12. Employee Telephone Number (Include Area Code)	S.I.C.
	13. Address-include Parish and Zip Code			14. Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Amer. Indian <input type="checkbox"/> Asian <input type="checkbox"/> Other		State-Parish
	15. <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		16. Number of Children Under 18	17. Date of Hire: MM/DD/YY		Occupation
	18. Present age	19. Occupation	20. Department or Division Regularly Employed		21. Employee's Date of Birth: MM/DD/YY	Nature of Injury
OCCURRENCE	22. Place of Injury-Employer's Premises <input type="checkbox"/> Yes <input type="checkbox"/> No		23. If No, Exact Location-Street, City, Parish and State			Part of Body
	24. What Was The Employee Doing When Injured? (Be specific. If using tools or equipment or handling material-name them and tell what he was doing with them)					Source of Injury
						Type of Accident
	25. How Did Injury Occur? (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 or contributed to injury or disease.)					Initials of Physician
						Address
						Usual Job
EMPLOYER	Did Injury or Disease Occur Because of:		26. Mechanical Defect <input type="checkbox"/> Yes <input type="checkbox"/> No (Describe Above)	27. Unsafe Act <input type="checkbox"/> Yes <input type="checkbox"/> No (Describe Above)	28. CHECK IF AMPUTATION <input type="checkbox"/>	Preexisting Condition
	29. Nature and Location of Injury or Disease (Describe fully, include parts of body affected)				30. OCC Disease-Date of Initial Diagn.	
	31. Attending Physician and Address (If Hospital involved indicate)					
	32. Employer			33. Person Completing This Report		
	34. Employer's Address-include Parish and Zip Code			35. Employer's Telephone Number (include Area Code)		
36. Employer's Mailing Address-If Different Than Above			37. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.			

- Employer Instructions and Wage Information on Reverse Side**
- Purpose of This Report
    - More than 7 days of disability
    - Injury resulted in death
    - Amputation or Disfigurement
    - Medical Only
    - Possible Dispute
  - Check whether this is a change of status from original notice sent to insurance carrier:
    - Yes  No
    - If yes, date disability began \_\_\_\_\_
    - Date employee returned to work \_\_\_\_\_
    - At same wage? Yes  No

WORKERS' COMPENSATION INSURANCE  
COMPANY AND ADDRESS  
(Preprint or Stamp-  
Include NCCI Self-Ins Number)

## INSTRUCTIONS TO EMPLOYER

1. Report of occupational injury (or disease), regardless of disability or medical expense, must be submitted to your insurance carrier immediately.
2. Report of occupational injury (or disease) must be filed with the Office of Workers' Compensation Administration no later than 10 days after the date of injury for all injuries resulting in more than 7 days of disability and for all injuries resulting in death.
3. Before sending copy of report to Office, be sure to check applicable block(s) on reverse side. ( Under Purpose of this Report)

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### WAGE INFORMATION

In the event of permanent disability, death, or disability beyond the 7 day waiting period, wages must be provided below:

Fixed Wage: \$ \_\_\_\_\_ Hourly \$ \_\_\_\_\_ Monthly \$ \_\_\_\_\_ Annual \$ \_\_\_\_\_ Other

If the amount entered is "Hourly" or "Other" fill out the appropriate section below:

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#### Hourly:

If "Hourly" and employee worked 40 hours per week or more, show the hours worked in the four full weeks preceding the date of accident.

Hours \_\_\_\_\_

If "Hourly" and employee worked less than 40 hours per week, show the average total earnings per week for the four full weeks preceding the date of accident.

\$ \_\_\_\_\_

If "Hourly" and employee is part-time, show the average hours worked in four full weeks preceding the date of accident.

Hours \_\_\_\_\_

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#### Other:

If "Other" and employee worked for a 26 week period or more, show the gross earnings in the 26 week period immediately preceding the accident and the number of days the employee worked for the employer during that same 26 week period.

\$ \_\_\_\_\_

Days \_\_\_\_\_

If "Other" and employee worked less than 26 weeks, show the gross earnings in the period immediately preceding the accident and the number of days the employee worked for the employer during that period.

\$ \_\_\_\_\_

Days \_\_\_\_\_

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### DISTRIBUTION OF THIS FORM

1. Insured Employee
2. Insurance Carrier
3. Office of Workers' Compensation
4. Attending Physician
5. Employer's File Copy