This form must be printed and sent to the NH Department of Labor and your insurance carrier.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

NH DOL USE ONLY

Return to: **The State of New Hampshire, Department of Labor**
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

IMPORTANT; *Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

1. Name of injured: First Middle Initial Last
2. DOB:
3. Age:
4. Male _ _ Female _ _
5. SS No.:
6. Address: No. & St. City/Town
7. State:
8. Zip Code:
9. Tel. No.:
10. Is there on file a N.H. Youth Employment Certificate?:
11. Occupation when injured:
12. Was this his/her regular occupation? If not, state regular occupation:
13. Wages per hr.:
14. No. hrs. worked per day:
15. No. days worked per week:
16. Average Weekly Earnings:
17. Was injured hired in N.H.?
18. Date employment began:
19. Date & Time of Injury:
20. Date disability began:
21. Was injured paid in full for this day?
22. Date supervisor/employer was first notified:
23. Name of Person notified:
24. Location/Jobsite where accident occured:
25. Describe fully how accident occurred and describe what employee was doing when injured:
26. Name of witness(es):
27. Part(s) of body injured:
28. Estimated length of disability:
29. Has injured returned to work?
30. If so, what date?
31. At what occupation or job?
32. Returned at: Full Duty: ____ ____ Alternative/Light Duty: ____ ____
33. Equipment causing injury:
34. Were safeguards in place?
35. Was accident caused by injured's failure to use safeguards or follow regulations?
36. Initial Treatment: (check those that apply) No medical treatment: _ _ Care provide by Employer only (on-site): _ _ Emergency care: _ _ Hospitalized: _ _
Other: (Outpatient): _ _ (Clinic): _ _ (Office Visit): _ _ (Other-explain): _____
37. Name of treating physician: Name of treating hospital:
38. Has injured died? If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name:
40. Employers Federal ID:
41. If leased or temporary worker, client's business name:
42. Business Address of No. 39 above:
43. City/State:
44. Zip:
45. Telephone Number:
46. Insurance Co. (**not agent**) or Self Insured Group:
47. Managed Care Program? Y or N. If yes, name Provider:
48. No. of Employees: Full-time: Part-time:
49. Is there a Written Safety Program **in force**?
50. Is there an **active** Safety Committee?
51. Business SIC Code
52. Type or Nature of Business in N.H.:
53. If report sent by Insurance Agency, state name:
54. Employer Signature:
55. Printed/Typed Name and Official Title:
56. Employee Signature (**whenever** possible):
57. Date of this report: