

MAIL TO:
 OFFICE OF WORKERS' COMPENSATION
 POST OFFICE BOX 94040
 BA TON ROUGE, LA. 70804-9040
 (225) 342-7565
 TOLL FREE (800) 201-3457

____ - ____ - ____
 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 10th day after the injury** or as requested by the OWCA.

PURPOSE OF REPORT: (Check all that apply)

- More than 7 days of disability Possible dispute Medical only
 Injury resulted in death Lump Sum Compromise/Settlement **(DO NOT mail copy to OWCA)**
 Amputation or disfigurement Other

1. Date of Report MM/DD/YY	2. Date / time of Injury MM/DD/YY Time __AM __PM	3. Normal Starting Time Day of Accident __AM __PM	4. If Back to Work - Give date MM/DD/YY	5. At same wage? __Yes __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. __ Male __ Female	12. Employee Phone # ()	S.I.C.
13. Address and Zip Code				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? __Yes __No		20. If No, Indicate Location-Street, City, Parish and State			Nature
21. What work activity was the employee doing when the injury occurred? (Give weight, size and shape of materials or equipment involved). Explain what employee was doing with them. Indicate if correct procedures were followed.					Part of Body
					Source
					Event
					NCCI
22. What caused injury to happen? (Describe fully the events which resulted in injury or disease. Explain what happened and how it happened. Name any objects or substances involved and explain 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. Employer's Mailing Address-If Different From Above				32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.	
33. Wage Information (optional) Employee was paid __ Daily __ Weekly __ Monthly __ Other. The average weekly wage was \$_____ per week.					

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of \$500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to \$10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than \$500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to \$10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to \$5,000.

EMPLOYER CERTIFICATION

I certify that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)

Signature Date

Company Name

Company Address

() _____

Phone Number

Insurance Policy Number

Employee Name

Employee Social Security Number