West Virginia Workers' Compensation Employers' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I Employer Information			
Insurer:	Third-Party Administrate		ator:
Employer's Name:	Nature of Business:		FEIN:
Address:			
City: Sta	te:	Zip:	Telephone: () -
Section II Employee Information			
Name: (Last): (First):		(M.I.):	Occupation/Job Title:
Address:			Telephone: () -
City: State:		Zip:	Social Security No.:
Date of Birth:/	6. Sex:	□F	Marital Status:
Injured Employee is (check all that apply):	Full-Time Part-	Time	Employee's Occupation/Job Title:
☐ Owner/Partner ☐ Officer ☐	Retired – Date Retired: _		
Section III Information Regarding Injury or Disease			
Date of Injury or Last Exposure://	Time:	☐ a.m. ☐ p.m.	Witnesses to Injury:
Date Employer Notified of Injury Supervi	sor to whom Injury or I	Disease	
or Disease:/ Reporte	ported:		
If Injury was Fatal, Indicate Date of Death:/			
Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address or location where injury			
occurred:			
What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, etc.):			
How did the Injury or Disease Occur (be specific; include time that employee began work on the date of injury, any equipment, tools, substances or objects connected to the injury; attach additional sheet if necessary):			
objects connected to the figury, attach additional sheet if necessary).			
Nature of Injury or Disease (cut, bruise, strain, etc.):			
Body Part(s) Injured:			
Are You Aware of, or Do You Suspect, a Prior Injury to this Body Part?			
Do You Have Reason to Question this Injury?			
Location of Initial Treatment:	Emergency Room? Yes No Hospitalized? Yes No		
Section IV Wage and Lost Time Information			
Date Hired:/	Last Day Worked After Occupational Injury or Disease:/		
Number of Work Days Lost:	Date of Return to Work	:: /	Hours Worked per Week:
Is Light Duty Available? Yes No	Wage on Date of Injury: \$ per hour day week month		
Are Wages Being Paid to Injured Employee	If Employee has Returned to Work, is it Alternative or Modified Work?		
During Disability?	If "yes," indicate current wage: \$ per hour day week month		
Daily rate of pay on the date of injury: \$ and best quarter wages of preceding four quarters \$			
I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically West Virginia Code §61-3-24e, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.			
Print Name: Title:			
Signature:		Date: /	/