

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.

1.	Name of injured: First	Middle Initial	Last	2. D	OB:	3. Age:	4. Male		5. SS No.:	
							Female			
6	Address: No. & St.	City/Town		7. S	ate.	8. Zip Code:		9. Tel. No	· ·	
0.				1. 0	ato.	0. Zip 0000.		0. 101.110		
10.	Is there on file a N.H. Youth Employment Certificate?:	11. Occupation when injured:		12. Was this his/h If not, state re	er regular occupat gular occupation:	ion?	13. Wages p	per hr.:	14. No. hrs. worked per day	
15	No. days worked per week:	16. Average Weekly Earnings	s 17 Was in	ured hired in N.H.?	18. Date emp	lovment began:]	19 Date & 7	Time of Injury:	
				,		,			,,,	
20.	Date disability began:	21. Was injured paid in full for this day?	22. Date supervisor was first notified		23. Name of Person		n notified: 24. Loca		cation/Jobsite where accident occured:	
25.	Describe fully how accident occurre	ed and describe what employee	I was doing when inju	red:						
26.	26. Name of witness(es):				27. Part(s) of body injured			28. Estimated length of disability:		
29.	9. Has injured returned to work? 30. If so, what date?			31. /	31. At what occupation or job? 32. Returned at: Full Duty:			•		
						T			rnative/Light Duty:	
33. Equipment causing injury: 34. W					afeguards in place? 35. Was accident caused by injured's failure to use safeguards or follow regulations?					
36.	6. 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.	37. Name of treating physician: Name of treating hospital:				38. Has injured died? If so, what date?			date?		
39.	Legal Business Name and/or D/B/A	40. Employers Fe	41. If lo	41. If leased or temporary worker, client's business name:						
42.	Business Address of No. 39 above:			4	3. City/State:				44. Zip:	
45.	Telephone Number:	Group:		47. Ma	47. Managed Care Program? Y or N. If yes, name Provider:					
48.	No. of Employees: Full-time:	ull-time: Part-time: 49. Is there a W			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.	4. Employer Signature:				55. Printed/Typed Name and Official Title:					
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