

# ACORD™ WISCONSIN EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

**Department of Workforce Development  
Worker's Compensation Division**  
201 E. Washington Avenue, Room 161  
P.O. Box 7901  
Madison, WI 53707-7901  
Telephone: (608) 266-1340  
http://www.dwd.state.wi.us/WC

An employer subject to the provisions of ch. 102, Wis. Stats., shall within one day after the death of an employee due to a compensable injury, report the death to the Department of Workforce Development (DWD) and to the employer's insurance carrier, if insured. In cases of permanent disability or where temporary disability results beyond the 3-day waiting period, an insured employer shall also notify its insurance carrier of a compensable injury or illness within 7 days after the injury or beginning of a disability from occupational disease related to the employee's compensable injury.

Insurance carriers and self-insured employers must report all relevant information on this form for all compensable claims to DWD within 14 days of the date of the injury.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].  
**See instructions for completing this form on reverse side.**

## EMPLOYEE INFORMATION

Employee Name (First, Middle, Last)				Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Employee Home Telephone Number	
Employee Street Address				City		State		Zip Code	
Occupation		Date of Hire Month Day Year		County and State where accident or exposure occurred					

## EMPLOYER INFORMATION

Employer Name				WI Unemployment Ins. Acct No.		Self-Insured? <input type="checkbox"/> YES <input type="checkbox"/> NO		Nature of Business (Specific Product)	
Employer Mailing Address				City		State		Zip Code	
Employer FEIN				Name of Worker's Compensation Insurance Company or Self-Insured Employer		Insurer FEIN			
Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer				TPA FEIN					

## WAGE INFORMATION

Wage at Time of Injury		Specify per hr., wk., mo., yr., etc.		In addition to Wages check boxes if Employee received:					
Is worker paid for overtime? If yes, after how many hours of work per week?		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> Meals		_____		No. of Meals per week	
				<input type="checkbox"/> Room		_____		No. of Days per week	
				<input type="checkbox"/> Tips		\$ _____		Average weekly amount	
Employee's Work Schedule When Injured		Start Time		Hours per Day		Hours per Week		Days per Week	
Employee's Normal Full-Time Schedule for Injured's Work									
For the 52 week period prior to the date the injury occurred, report the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.				Number of Weeks		Gross Amount Excluding Tips \$		If Piece Work - No/Hrs. excluding overtime	
Part-Time employment Information		Schedule Hours per Week		Are there other part time workers doing the same work with the same schedule? If yes, how many?		<input type="checkbox"/> YES <input type="checkbox"/> NO		Number of full-time employees doing the same type of work.	

## INJURY INFORMATION

Date of Injury Month Day Year			Time of Injury AM PM			Last Day Worked Month Day Year			Date Employer Notified Month Day Year			Date Returned to Work Month Day Year		
Was this a lost time or other compensable injury? <input type="checkbox"/> YES <input type="checkbox"/> NO			If no, insurer does not submit report to DWD.			Did injury occur as a result of? <input type="checkbox"/> Substance Abuse			<input type="checkbox"/> Failure to Use Safety Devices			<input type="checkbox"/> Failure to Obey Rules		
Did injury cause death? <input type="checkbox"/> YES <input type="checkbox"/> NO			Name of Closest Dependent of Deceased if Injury Caused Death						Relationship					
Date of Death Month Day Year			Address											
Name of Witness														
Name of Treating Practitioner and Hospital														
Address of Treating Practitioner and Hospital														
Injury Description - What happened to cause this injury or illness? Describe the employee's activities when the injury or illness occurred with details of how the event or exposure occurred. Include name(s) of other individuals involved. Specify tools, machinery, objects, chemicals, etc. that were involved in or caused the injury.														
Report Prepared By				Work Phone No.				Position				Date Signed		

WKC-12 (R. 2/98)

**SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT**

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INSTRUCTIONS ON REVERSE SIDE

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## EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of the work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or third party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of the work injury.

## MANDATORY INFORMATION

**In order to accurately administer claims, each of the following sections of this form must be completed.** The First Report of Injury will be returned to the sender if the mandatory information is not provided.

**Employee Section:** Provide all requested information to identify the injured employee. If an employee had multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

**Employer Section:** Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

**Wage Information Section:** Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

**Injury Information Section:** Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed.

## REMARKS