Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a $5,000 fine. (Sec 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured employee a copy of this report.

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

CASE NUMBER

NOTE: DO NOT WRITE IN SHADED BLOCKS

IDENTIFICATION SECTION

EMPLOYEE NAME – LAST	FIRST	M.I.	SOC SEC NO	DATE OF BIRTH	SEX	MARITAL STATUS	DATE RECEIVED
				MM / DD / YY	MALE ☐ FEMALE ☐	MARRIED ☐ SINGLE ☐	MM / DD / YY

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE

PHONE	OCCUPATION	DATE HIRED	YRS EMP'D CODE	DEPARTMENT	PAYROLL COMP CLASS CODE	OCC. CODE
		MM / DD / YY				

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED	DATE OF INJURY/ILLNESS	PREFAB	DOL NUMBER	DBA
		MM / DD / YY	MM / DD / YY	☐ WC-2 ☐ WC-5		

DETAIL OF INJURY / ILLNESS

TIME OF INJURY/ILLNESS	TIME OF I/I CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS	CITY	STATE	ON EMPLOYER'S PREMISES	INDUSTRIAL CODE
_____AM _____PM					☐ YES ☐ NO	

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary)

TIME WORK SHIFT BEGAN _____ AM _____ PM

SOURCE OF INJURY	EVENT

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using)

TASK	ACTIVITY	ACCIDENT FACTOR

AOS

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him; the vapor or poison inhaled or swallowed; the chemical that irritated employee's skin. In cases of strains, the object employee was lifting, pulling, etc.)

DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED

	YES	NO	NATURE OF INJURY	PART OF BODY
DISFIGUREMENT	☐	☐		
BURNS	☐	☐		

TIME LOST INFORMATION

DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISHED MEALS OR LODGING?	AVG WKLY WAGE	IF EMPLOYEE IS BACK TO WORK GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS?	IF EMPLOYEE DIED GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS WAKED /WK	WEIGHING FACTOR
MM / DD / YY	☐ YES ☐ NO		MM / DD / YY	☐ YES ☐ NO	MM / DD / YY				

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN	ADDRESS	PHYSICIAN I.D. CODE

NAME OF MEDICAL FACILITY	ADDRESS	YES	NO
		INPATIENT OVERNIGHT? ☐	☐
		EMERGENCY ROOM ONLY? ☐	☐

INSURANCE

CARRIER I.D.

NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY	IF LIABILITY DENIED – WHY?	IS LIABILITY DENIED?
			☐ YES ☐ NO

POLICY NO.	POLICY PERIOD	ADJUSTER NAME	CARRIER CASE NO.

SIGNATURE

	ADJUSTER I.D.	MEDICAL DEDUCTIBLE

	TITLE	DATE
		MM / DD / YY

WC-1 (Rev. SEPT/16)