MAIL TO:
OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON 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
- ☐ Injury resulted in death
- ☐ Amputation or disfigurement
- ☐ Possible dispute
- ☐ Lump Sum Compromise/Settlement
- ☐ Other
- ☐ Medical only **ú ú ú** **("DO NOT mail copy to OWCA.")**

1.Date ofReport MM/DD/YY	2. Date / time of Injury MM/DD/YY Time ☐AM ☐M	3. Normal Starting Time Day of Accident ☐AM ☐PM	4. If Back toWork - 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.					

LDOL-WC-1007
REV. 10/98

NAME OF WORKERS' COMPENSATION INSURER

PHONE NUMBER ( )