MAIL TO:
OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA. 70804-9040
(504) 342-7565

_____-_____-___________
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 incident** 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 **(no copy needed by OWCA)**

					DO NOT WRITE IN THIS COLUMN
1. Date or Report MM/DD/YY	2. Date/time of Injury: MM/DD/YY ☐ AM ☐ PM	3. Normal Starting Time Day of Accident: ☐ AM ☐ PM	4. If Back to Work - Give Date: MM/DD/YY	5. At same wage? ☐ Yes ☐ No	
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			14. Parish of Injury		State-Parish
15. Date of Hire	16. Age at Illness/Injury	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 incident occurred? (Give weight, size and shape of materials or equipment involved. Tell what he was doing with them. Indicate if correct procedures were followed.)					Part of Body
					Source
					Event
					NCCI

22. What caused incident to happen? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell 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 Name	26. Hospital name
27. Employer's Name	28. Person Completing This Report-Please Print
29. Employer's Address	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 wage per week was $_________ per week.	

NAME OF WORKERS' COMPENSATION INSURER:
PHONE NUMBER: ( )

COMPLETE BOTH SIDES

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of $500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to $10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than $500, or imprisoned with or without hard labor for not more than one year, or both.

If it unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to $10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000.

EMPLOYER CERTIFICATION

I certify that I can read the English language, that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT) ____________ Signature ____________ Date ____________

Company Name ____________ Company Address ____________

Phone Number ____________ Insurance Policy Number ____________

Employee First Name ____________ Last Name ____________ Employee Social Security Number ____________

UNIFORM INFORMATION SERVICES, INC.

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