

## West Virginia Workers' Compensation Employers' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I Employer Information			
Insurer:		Third-Party Administrator:	
Employer's Name:		Nature of Business:	FEIN:
Address:			
City:	State:	Zip:	Telephone: (    ) -
Section II Employee Information			
Name: (Last):		(First):	(M.I.):
Occupation/Job Title:			Telephone: (    ) -
Address:			Social Security No.: - -
City:	State:	Zip:	
Date of Birth: ____/____/____	6. Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status:
Injured Employee is (check all that apply): <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Volunteer <input type="checkbox"/> Owner/Partner <input type="checkbox"/> Officer <input type="checkbox"/> Retired - Date Retired: ____/____/____			Employee's Occupation/Job Title:
Section III Information Regarding Injury or Disease			
Date of Injury or Last Exposure: ____/____/____		Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Witnesses to Injury:
Date Employer Notified of Injury or Disease: ____/____/____	Supervisor to whom Injury or Disease Reported:		
If Injury was Fatal, Indicate Date of Death: ____/____/____			
Did Injury Occur on Employer's Property? <input type="checkbox"/> Yes <input type="checkbox"/> No    Address or location where injury occurred:			
What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, etc.):			
How did the Injury or Disease Occur (be specific; include time that employee began work on the date of injury, any equipment, tools, substances or objects connected to the injury; attach additional sheet if necessary):			
Nature of Injury or Disease (cut, bruise, strain, etc.):			
Body Part(s) Injured:			
Are You Aware of, or Do You Suspect, a Prior Injury to this Body Part? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do You Have Reason to Question this Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No    (If "yes," attach a specific explanation to this form).			
Location of Initial Treatment:		Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No
Section IV Wage and Lost Time Information			
Date Hired: ____/____/____		Last Day Worked After Occupational Injury or Disease: ____/____/____	
Number of Work Days Lost:		Date of Return to Work: ____/____/____	Hours Worked per Week:
Is Light Duty Available? <input type="checkbox"/> Yes <input type="checkbox"/> No		Wage on Date of Injury: \$                      per <input type="checkbox"/> hour <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	
Are Wages Being Paid to Injured Employee During Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Employee has Returned to Work, is it Alternative or Modified Work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," indicate current wage: \$                      per <input type="checkbox"/> hour <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	
Daily rate of pay on the date of injury: \$		and best quarter wages of preceding four quarters \$	
I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically West Virginia Code §61-3-24e, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.			
Print Name: _____		Title: _____	
Signature: _____		Date: ____/____/____	

## West Virginia Workers' Compensation Employees' and Physicians' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

### Section I Employee's Claim Information

<b>Insurer:</b>		<b>Third-Party Administrator:</b>	
1. Name: (Last): _____ (First): _____ (M.I.): _____		3. Telephone: ( ) - -	
2. Address: City: _____ State: _____ Zip: _____		4. Social Security No.: - - -	
5. Date of Birth: ____/____/____	6. Sex: <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status:	
8. Date of Injury or Last Exposure: ____/____/____ Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		9. Time You Began Work on Date of Injury: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
10. Date You Stopped Working Due to Injury: ____/____/____			
11. Have You Retired? <input type="checkbox"/> yes <input type="checkbox"/> no		If "yes," what was the date you retired: ____/____/____	
12. Employer's Name: Address: City: _____ State: _____ Zip: _____ Telephone: ( ) - -		Supervisor's Name:	
13. Job Title/Description:			
14. Body Part(s) Injured:			
15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment/objects involved):			
16. Did Injury Occur on Employer's Property? <input type="checkbox"/> Yes <input type="checkbox"/> No Address where injury occurred:			
17. Please Identify Any Witnesses to Your Injury:			

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Section II All Information Must Be Completed by Initial Healthcare Provider

1. Name of Physician/Hospital:		2. FEIN/Social Security No.: - - -	
3. Address: City: _____ State: _____ Zip: _____ Telephone: ( ) - -			
4. Date of Initial Treatment: ____/____/____		5. Date Patient May Return to Work: ____/____/____	
6. Have you advised the patient to remain off work 4 or more days? <input type="checkbox"/> Yes. Indicate dates: from _____ to _____ <input type="checkbox"/> No. If "no," is the patient capable of <input type="checkbox"/> Full Duty <input type="checkbox"/> Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:			
7. Condition is a direct result of: <input type="checkbox"/> Occupational Injury? <input type="checkbox"/> Occupational Disease? <input type="checkbox"/> Non-Occupational Condition?			
8. Did this injury aggravate a prior injury/disease? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, explain:			
9. Description of injury or occupational disease:			
10. Body part(s) injured:		11. ICD9-CM Diagnosis Code(s) in order of severity:	
12. Name of physician referred to:		13. If the patient was hospitalized, where?	

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_