WISCONSIN

ACORD 4 WI (2003/04) - Wisconsin Employer's First Report of Injury or Disease

Section Name	Field Name	Field and/or Section Description
TITLE **ACORD 4 WI (2003/04)**	**Wisconsin Employer's First Report of Injury or Dis**	The title of the form. ACORD 4 WI, Wisconsin Employer's First Report of Injury or Disease, is used to report a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. Instructions for the completion of ACORD 4 WI are found on page 2 of this form.
EMPLOYEE INFORMATION	**Name (First, Middle, Last)**	Enter text: The employee's first name (given name).
EMPLOYEE INFORMATION		Enter text: The employee's middle name or initial (other given name).
EMPLOYEE INFORMATION		Enter text: The employee's last name (surname).
EMPLOYEE INFORMATION	**Social Security Number**	Enter identifier: The tax identifier of the employee.
EMPLOYEE INFORMATION	**Sex Male**	Check the box (if applicable): Indicates the employee is male.
EMPLOYEE INFORMATION	**Sex Female**	Check the box (if applicable): Indicates the employee is female.
EMPLOYEE INFORMATION	**Employee Home Phone Number**	Enter number: The primary phone number of the employee.
EMPLOYEE INFORMATION	**Employee Street Address**	Enter text: The first address line of the employee's mailing address.
EMPLOYEE INFORMATION	**City**	Enter text: The city of the employee's mailing address.
EMPLOYEE INFORMATION	**State**	Enter code: The state or province code of the employee's mailing address.
EMPLOYEE INFORMATION	**Zip**	Enter code: The postal code of the employee's mailing address.
EMPLOYEE INFORMATION	**Occupation**	Enter text: The occupation of the employee.
EMPLOYEE INFORMATION	**Birth Date Month**	Enter number: The month of the employee's birth.
EMPLOYEE INFORMATION	**Birth Date Day**	Enter number: The day of the month of the employee's birth.
EMPLOYEE INFORMATION	**Birth Date Year**	Enter year: The year of the employee's birth.
EMPLOYEE INFORMATION	**Date of Hire**	Enter date: The hire date of the employee.
EMPLOYEE INFORMATION	**County and State where accident or exposure occurred**	Enter text: The loss location's county name.
EMPLOYEE INFORMATION		Enter code: The loss location's state or province code.
EMPLOYER INFORMATION	**Employer Name**	Enter text: The named insured(s) as it / they will appear on the policy declarations page.
EMPLOYER INFORMATION	**WI Unemployment Ins. Acct. No.**	Enter identifier: The named insured's state unemployment account number.
EMPLOYER INFORMATION	**Self-Insured? Yes**	Check the box (if applicable): Indicates the insured is self-insured, in whole or in part.

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EMPLOYER INFORMATION	**Self-Insured? No**	Check the box (if applicable): Indicates the insured is not self-insured, in whole or in part.
EMPLOYER INFORMATION	**Nature of Business (Specific Product)**	Enter text: The description of the other nature / type of business.
EMPLOYER INFORMATION	**Employer Mailing Address**	Enter text: The named insured's mailing address line one.
EMPLOYER INFORMATION	**City**	Enter text: The named insured's mailing address city name.
EMPLOYER INFORMATION	**State**	Enter code: The named insured's mailing address state or province code.
EMPLOYER INFORMATION	**Zip**	Enter code: The named insured's mailing address postal code.
EMPLOYER INFORMATION	**Employer FEIN**	Enter identifier: The tax identifier of the named insured.
EMPLOYER INFORMATION	**Name of Workers Compensation Insurance Company or Self-Insured Employer**	Enter text: The insurer's full legal company name(s) as found in the file copy of the policy. Use the actual name of the company within the group to which the policy has been issued. This is not the insurer's group name or trade name.
EMPLOYER INFORMATION	**Insurer FEIN**	Enter identifier: The tax identifier of the insurer.
EMPLOYER INFORMATION	**Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer**	Enter text: The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.
EMPLOYER INFORMATION		Enter text: The first address line of the claim administrator's mailing address.
EMPLOYER INFORMATION		Enter text: The city of the claim administrator's mailing address.
EMPLOYER INFORMATION		Enter code: The state or province code of the claim administrator's mailing address.
EMPLOYER INFORMATION		Enter code: The postal code of the claim administrator's mailing address.
EMPLOYER INFORMATION	**TPA FEIN**	Enter identifier: The tax identifier of the claim administrator.
WAGE INFORMATION	**Wage at Time of Injury**	Enter amount: The employee's average wage amount.
WAGE INFORMATION	**Specify per hr., wk., mo., yr., etc.**	Enter code: Indicates the frequency at which the average wage amount is paid.
WAGE INFORMATION	**Is worker paid overtime ? Yes**	Check the box (if applicable): Indicates the employee receives overtime pay.
WAGE INFORMATION	**Is worker paid overtime ? No**	Check the box (if applicable): Indicates the employee does not receive overtime pay.
WAGE INFORMATION	**If "Yes", after how many hours per week.**	Enter number: The number of hours an employee must work per week prior to being paid for overtime.
WAGE INFORMATION	**Check boxes if employee received: Meals**	Check the box (if applicable): Indicates the employee received meals in addition to their wages.
WAGE INFORMATION	**Number of Meals per Week**	Enter number: The number of meals per week the employee received.

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WAGE INFORMATION	**Check boxes if employee received: Room**	Check the box (if applicable): Indicates the employee received a room in addition to their wages.
WAGE INFORMATION	**Number of Days per Week**	Enter number: The number of days per week the employee received a room..
WAGE INFORMATION	**Check boxes if employee received: Tips**	Check the box (if applicable): Indicates the employee received tips in addition to their wages.
WAGE INFORMATION	**Average Weekly Amount**	Enter amount: The average weekly amount of tips the employee received.
WAGE INFORMATION	**Employee's Work Schedule when injured: Start Time**	Enter time: The employee's scheduled start time when injured.
WAGE INFORMATION	**Employee's Work Schedule when injured: Hours per Day**	Enter number: The number of hours per day the employee was working when injured.
WAGE INFORMATION	**Employee's Work Schedule when injured: Hours per Week**	Enter number: The number of hours per week the employee was working when injured.
WAGE INFORMATION	**Employee's Work Schedule when injured: Days per Week**	Enter number: The number of days per week the employee was working when injured.
WAGE INFORMATION	**Employee's Normal Full-Time Schedule for Injured's Work: Start Time**	Enter time: The employee's normal full time scheduled start time.
WAGE INFORMATION	**Employee's Normal Full-Time Schedule for Injured's Work: Hours per Day**	Enter number: The number of hours per day the employee works when on their normal full-time schedule.
WAGE INFORMATION	**Employee's Normal Full-Time Schedule for Injured's Work: Hours per Week**	Enter number: The number of hours per week the employee works when on their normal full-time schedule.
WAGE INFORMATION	**Employee's Normal Full-Time Schedule for Injured's Work: Days per Week**	Enter number: The number of days per week the employee works when on their normal full-time schedule.
WAGE INFORMATION	**Number of Weeks**	Enter number: The number of weeks worked in the 52 weeks prior to the injury / illness occurring.
WAGE INFORMATION	**Gross Amount Excluding Tips**	Enter amount: The gross wages amount, excluding tips, in the 52 weeks prior to the injury / illness occurring.
WAGE INFORMATION	**If Piece Work Number of Hours Excluding Over Time**	Enter number: The number of pieces per hour, excluding overtime, in the 52 weeks prior to the injury / illness occurring.
WAGE INFORMATION	**Schedule Hours per Week**	Enter number: The number of hours scheduled per week for a part-time employee.

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WAGE INFORMATION	**Are there other part-time workers doing the same work with the same schedule? Yes**	Check the box (if applicable): Indicates there are other part-time workers doing the same work with the same schedule.
WAGE INFORMATION	**Are there other part-time workers doing the same work with the same schedule? No**	Check the box (if applicable): Indicates there are not other part-time workers doing the same work with the same schedule.
WAGE INFORMATION	**Number of part-time employees doing the same kind of work.**	Enter number: The number of other part-time workers doing the same work with the same schedule.
WAGE INFORMATION	**Number of full-time employees doing the same kind of work.**	Enter number: The number of full-time employees doing the same type of work.
INJURY INFORMATION	**Date of Injury Month**	Enter number: The month the loss occurred.
INJURY INFORMATION	**Date of Injury Day**	Enter number: The day of the month the loss occurred.
INJURY INFORMATION	**Date of Injury Year**	Enter year: The year the loss occurred.
INJURY INFORMATION	**Time of injury AM**	Enter time: The approximate time that the loss occurred.
INJURY INFORMATION	**Time of injury PM**	Enter time: The approximate time that the loss occurred.
INJURY INFORMATION	**Last Day Worked Month**	Enter number: The month in which the employee last worked.
INJURY INFORMATION	**Last Day Worked Day**	Enter number: The day of the month the employee last worked.
INJURY INFORMATION	**Last Day Worked Year**	Enter year: The year the employee last worked.
INJURY INFORMATION	**Date Employer Notified Month**	Enter number: The month the employer was notified or became aware of the employee's work related disability / incapacity.
INJURY INFORMATION	**Date Employer Notified Day**	Enter number: The day of the month the employer was notified or became aware of the employee's work related disability / incapacity.
INJURY INFORMATION	**Date Employer Notified Year**	Enter year: The year the employer was notified or became aware of the employee's work related disability / incapacity.
INJURY INFORMATION	**Date Returned to Work (checkbox)**	Check the box (if applicable): Indicates the return to work date is the actual date the employee returned to work.
INJURY INFORMATION	**Estimated Date of Return (checkbox)**	Check the box (if applicable): Indicates the return to work date is the estimated date the employee will return to work.
INJURY INFORMATION	**Month**	Enter number: The day the claimant returned / will return to work.
INJURY INFORMATION	**Day**	Enter number: The month the claimant returned / will return to work.
INJURY INFORMATION	**Year**	Enter year: The year the claimant returned / will return to work.
INJURY INFORMATION	**Was this a lost time or other compensable injury? Yes**	Check the box (if applicable): Indicates this is a lost time or compensable injury.

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INJURY INFORMATION	**Was this a lost time or other compensable injury? No**	Check the box (if applicable): Indicates this is not a lost time or compensable injury.
INJURY INFORMATION	**Did injury occur as a result of: Substance Abuse**	Check the box (if applicable): Indicates the cause of loss is a result of substance abuse.
INJURY INFORMATION	**Did injury occur as a result of: Failure to Use Safety Devices**	Check the box (if applicable): Indicates the cause of loss is a result of the failure to use safety devices.
INJURY INFORMATION	**Did injury occur as a result of: Failure to Obey Rules**	Check the box (if applicable): Indicates the cause of loss is a result of the failure to obey rules.
INJURY INFORMATION	**Did injury cause death? Yes**	Check the box (if applicable): Indicates the incident resulted in a fatality.
INJURY INFORMATION	**Did injury cause death? No**	Check the box (if applicable): Indicates the incident did not result in a fatality.
INJURY INFORMATION	**Date of Death Month**	Enter number: The month of the employee's date of death.
INJURY INFORMATION	**Date of Death Day**	Enter number: The day of the month of the employee's date of death.
INJURY INFORMATION	**Date of Death Year**	Enter year: The year of the employee's date of death.
INJURY INFORMATION	**Name of Closest Dependent of Deceased if injury caused death**	Enter text: The full name of the employee's closest dependent.
INJURY INFORMATION	**Relationship**	Enter code: The relationship of the dependent to the employee. Examples are: I - Insured; S - Spouse; C - Child; SIB - Brother or Sister; P - Parent; E - Employee.
INJURY INFORMATION	**Address Line 1**	Enter text: The employee's closest dependent's first address line.
INJURY INFORMATION	**Address Line 2**	Enter text: The employee's closest dependent's second address line.
INJURY INFORMATION	**Address Line 3**	Enter text: The employee's closest dependent's city name.
INJURY INFORMATION		Enter code: The employee's closest dependent's state or province code.
INJURY INFORMATION		Enter code: The employee's closest dependent's postal code.
INJURY INFORMATION	**Name of witness**	Enter text: The name of a person that was a witness to the incident or an uninjured passenger.
INJURY INFORMATION	**Name of Treating Practitioner and Hospital**	Enter text: The full name of the physician.
INJURY INFORMATION	**Address of Treating Practitioner and Hospital Line 1**	Enter text: The physician's first mailing address line.
INJURY INFORMATION	**Address of Treating Practitioner and Hospital Line 2**	Enter text: The physician's second mailing address line.
INJURY INFORMATION	**Address of Treating Practitioner and Hospital Line 3**	Enter text: The physician's mailing address city name.
INJURY INFORMATION		Enter code: The physician's mailing address state or province code.

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INJURY INFORMATION		Enter code: The physician's mailing address postal code.
INJURY INFORMATION		Enter text: The name of the hospital.
INJURY INFORMATION		Enter text: The hospital's mailing address line one.
INJURY INFORMATION		Enter text: The hospital's mailing address line two.
INJURY INFORMATION		Enter text: The hospital's mailing address city.
INJURY INFORMATION		Enter text: The hospital's mailing address state or province code.
INJURY INFORMATION		Enter text: The hospital's mailing address line postal code.
INJURY INFORMATION	**Injury Description**	Enter text: The description of how injury or illness / abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill, (e.g., Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal).
INJURY INFORMATION	**Report Prepared by**	Enter text: The name of the individual that prepared the claim form.
INJURY INFORMATION	**Work Phone No.**	Enter number: The phone number of the individual that prepared the claim form.
INJURY INFORMATION	**Position**	Enter text: The title of the individual that prepared the claim form.
INJURY INFORMATION	**Date Signed**	Enter date: The date the preparer signed the form.
REMARKS	**Remarks**	Enter text: The workers compensation first report or injury/illness general remarks.