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

NOTE: DO NOT WRITE IN SHADED BLOCKS

CASE NUMBER

IDENTIFICATION SECTION

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

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

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

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

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

DETAIL OF INJURY / ILLNESS

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

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 WORKSHIFT 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
DISFIGUREMENT	☐	☐
BURNS	☐	☐

NATURE OF INJURY | PART OF BODY

TIME LOST INFORMATION

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

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.

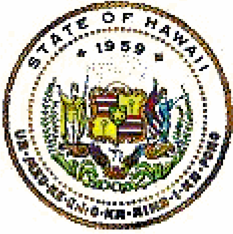
NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY	IF LIABILITY DENIED – WHY?	IS LIABILITY DENIED? ☐ YES ☐ NO

POLICY NO.	POLICY PERIOD -	ADJUSTER NAME	CARRIER CASE NO.

ADJUSTER I.D. | MEDICAL DEDUCTIBLE

SIGNATURE

	TITLE	DATE MM / DD / YY



STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-5A DEPENDENTS' CLAIM FOR COMPENSATION

Instructions

Please completely fill out the WC-5A DEPENDENTS' CLAIM FOR COMPENSATION FORM.

If you are represented, please provide the name and address of your representative.

Please attach the following supporting documents as applicable: Death Certificate, Marriage Certificate, and Birth Certificates of Dependents, if any.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail

Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

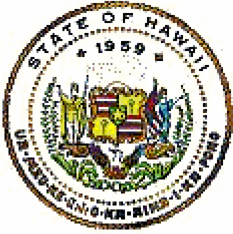
Delivery In-Person

Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

Delivery via Fax

Department of Labor and Industrial Relations, Disability Compensation Division
(808) 586-9219

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.



STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

FORM WC-5A DEPENDENTS' CLAIM FOR COMPENSATION

Deceased Person

Name of Claimant	Date of Death
Place of Death	Date of Injury Causing Death
Nature of Injury Causing Death	

Survivors of Claimant

Name of Dependent	Relation to Deceased	Telephone No. ( )
Address		
Other Dependents		
Name	Birth Date (if a minor)	Registry No. (if a minor)

Deceased's Employer

Name
Address

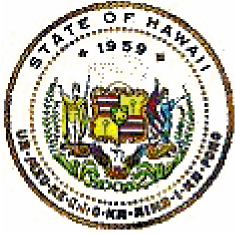
Employer's Insurance Carrier

Name
Address

I hereby make claim on behalf of myself and the dependents listed above for compensation arising out of the death of the above named deceased person.

Print Name	Signature	Date
Name of Representative	Telephone No. ( )	
Address of Representative		

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.



STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-5
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Instructions

IMPORTANT:
If information provided is incomplete, this claim will not be processed and will be returned to the employee. Please complete the form in triplicate. Please distribute the form as follows: original and one copy to the appropriate District Office (see next page) and one copy for employee's records.

Ensure information indicated is CLEAR, LEGIBLE, COMPLETE AND ACCURATE.

INJURED PERSON:
Name: Enter full, complete name shown on injured person's social security identification card (no nicknames). Address: Enter mailing address.

EMPLOYER:
Name: Enter the complete business name of the employer.
Address: Enter full address of employer including city, state and zip code.

INSURANCE CARRIER:
Name: Enter the name of the insurance company that handles workers' compensation for the employer.

INJURY:
Date of Accident: Enter specific date injury occurred.
Time: Specify time and include a.m. or p.m.
Describe Injury/Illness: How and where did the accident occurred?
Reason for Filing: Specify reason(s) for filing this claim.

WITNESS:
Enter name and address of someone who saw accident, if any.

NOTICE:
Indicate whether you notified your employer of the injury.

ATTENDING PHYSICIAN:
Enter name and address of the physician who treated you for this injury and attach available medical reports to this claim.

REPRESENTED BY:
You may leave this part blank, but if you are represented, enter the name and address of attorney/union agent, or other representative.

Address: Enter full address of your representative to include city, state and zip code.

SIGNATURE OF CLAIMANT:
Sign your name and date.

ATTACHMENTS: (if available)
(i.e. Physician medical reports, Attorney letter of representation, etc.)

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

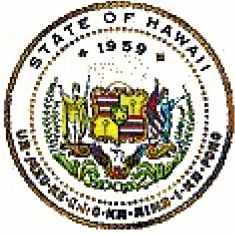
Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail, In-Person, or via Fax

Department of Labor and Industrial Relations, Disability Compensation Division

Oahu	Kauai	Maui
Princess Keelikolani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaii 96813 Mailing Address: P.O. Box 3769 Honolulu, Hawaii 96812-3769 Phone: (808) 586-9161 Fax: (808) 586-9219	3060 Eiwa Street, Room 202 Lihue, Hawaii 96766 Phone: (808) 274-3351 Fax: (808) 274-3355	2264 Aupuni Street, #2 Wailuku, Hawaii 96793 Phone: (808) 984-2072 Fax: (808) 984-2071
Hawaii	**West Hawaii**	
75 Aupuni Street, Room 108 Hilo, Hawaii 96720 Phone: (808) 974-6464 Fax: (808) 974-6460	Ashikawa Building 81-990 Halekii Street, Room 2087 Kealakekua, Hawaii 96750 If Mailing, Please Mail to This Address: P.O. Box 49, Kealakelua, Hawaii 96750 Phone: (808) 322-4808 Fax: (808) 322-4813	



STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

FORM WC-5
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Injured Person

Name	
Address	
Occupation	
Telephone No. ( )	Social Security No.

Employer

Name	
Address	
Nature of Business	Telephone No. ( )

Insurance Carrier

Name
Address

Injury

Date of Accident	Time of Injury a.m. p.m.	Date Disability Began
If not on employer's premises, indicate place where accident occurred		
Describe how accident occurred		
Describe injury/illness		

Reason for filing:

☐ Employer has not filed WC-1 ☐ Reopening of old claim ☐ Insurance carrier has not paid benefits

☐ Others (explain)

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

Witness

Name	Work Phone ( )	Home Phone ( )
Address		

Name	Work Phone ( )	Home Phone ( )
Address		

Notice

Did you notify the employer of the injury? ☐ Yes ☐ No If so, when:
How: ☐Oral ☐Written To whom:

Attending Physician

Name	Telephone No. ( )
Address	

I hereby present my claim for compensation for disability resulting from the foregoing injury arising out of and in the course of my employment and not caused by my intoxication nor by my willful intention to injure myself or another individual.

I hereby authorize any physician and/or hospital to release any information related to any treatment rendered to me.

Represented by ______________________________ ______________________________
ATTORNEY/UNION AGENT SIGNATURE OF CLAIMANT

Address____ Date ____________

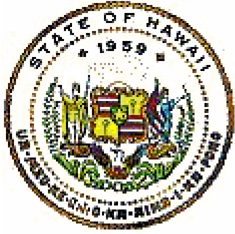
____

____

Auxiliary aids and services are available upon request. Please call: (808) 586-9174; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.



STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-14
EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

Instructions

Please completely fill out the WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS FORM.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

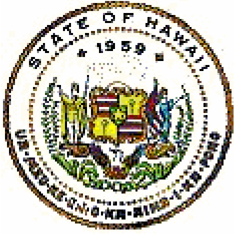
Delivery Information

Delivery by U.S. Mail
Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

Delivery In-Person
Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

Delivery via Fax
Department of Labor and Industrial Relations, Disability Compensation Division
(808) 586-9219

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.



STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

FORM WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS PRIOR TO DATE OF INJURY

Employee:	SS No.:	Case No.: - -	Date of Injury:

The above employee reported employment with your firm Under the Hawaii Workers' Compensation Law; an employee's benefits are calculated based on wages earned. Please assist us in determining benefits by completing this form

Employer:	Employee's Occupation:	Hourly Rate:
Date Employed:	Presently Employed?	If terminated, date:
Disabled from:	through:	Returned to Work:
Indicate the days and hours normally worked:		

Sunday:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:
If other than the above, please indicate:						

Please call Records and Claims Branch at 586-9161 if you have Questions

Employer:	Telephone: ( )
Address	
Date:	By:

(To be signed in ink)

Auxiliary aids and services are available upon request. Please call: (808) 586-9161; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

Employee:	SS No.:	Case No.: - -	Date of Injury:

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
	Total									
This statement of Employee's earnings is taken from our Payroll Records.										

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										
37										
38										
39										
40										
41										
42										
43										
44										
45										
46										
47										
48										
49										
50										
51										
52										
	Total									
This statement of Employee's earnings is taken from our Payroll Records.										