WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE SELF INSURANCE ☐	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	☐ YES ☐ YES	☐ NO ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED	☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

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

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?	☐ YES ☐ NO ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

EMPLOYEE
CERTIFICATE OF COMPLIANCE

You must submit this form to your employer's workers' compensation insurer or to your employer within 14 days of its receipt. Your workers' compensation **benefits may be suspended if you do not timely submit this Certification.** You would be entitled to all suspended benefits after this Certification is provided to your insurer, if you are otherwise eligible for benefits.

It is unlawful for you to work and receive workers' compensation disability benefits, except for supplemental earnings benefits. Supplemental earnings benefits are paid when an employee is able to work, but is unable to earn 90% or more of his pre-injury wages as a result of a job related accident. As an injured worker, you must notify your employer or insurer of the earning of any wages, changes in employment or medical status, receipt of unemployment benefits, receipt of social security benefits and receipt of retirement benefits. If you receive benefits for more than 30 days, you will be required to certify your earnings to your insurer quarterly.

It is unlawful for you to receive workers' compensation indemnity disability benefits and unemployment benefits at the same time, except for permanent partial disability benefits. Permanent partial disability benefits are paid solely for amputation or for anatomical loss of use of a body part or function. If you violate this provision, you may be fined up to $10,000, imprisoned up to 90 days, or both.

It is 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, imprisoned, or both, as follows:

Unlawful Benefits Paid or Claimed	**Fine**	**Imprisonment**
$10,000 or more	up to $10,000	up to 10 years, with or without hard labor
$2,500 or more but less than $10,000	up to $ 5,000	up to 5 years, with or without hard labor
less than $2,500	up to $500	up to 6 months

In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000 and may forfeit your right to receive workers' compensation benefits.

EMPLOYEE CERTIFICATION

I certify that I understand the contents of this entire document, and that I understand I am held responsible for this information. I certify my compliance with the above stated requirements regarding receipt of workers' compensation benefits.

Print Name	Signature	Social Security Number	Date

Address	City	State / Zip	( ) Phone Number

Note: Only one copy is required per case from the employee.
Please mail this form to your employer or your employer's insurer.

LWC-WC-1025.EE
REVISED 07/2008

LOUISIANA TRABAJA
Departamento del Trabajo

OFICINA DE COMPENSACION LABORAL

CERTIFICADO DE CONFORMIDAD DEL TRABAJADOR

Usted tiene la obligación de proporcionar este formulario a su asegurador de compensación laboral o a su empleador dentro de los 14 días siguientes de haberlo recibido. Los beneficios de compensación laboral **pueden ser suspendidos si usted no somete este formulario a tiempo.** Usted puede tener derecho a todos los beneficios que han sido suspendidos después que esta certificación es proporcionada a su asegurador, si usted de otra manera es elegible para beneficios.

Está fuera de la ley que usted esté trabajando y recibiendo beneficios de indemnización de compensación laboral, exceptuando beneficios suplementales ganados. Beneficios Suplementales ganados son pagados cuando el empleado esta capacitado para trabajar, pero no puede ganar el 90% o más del salario que ganaba antes de la lesión o accidente de trabajo. Como un trabajador lesionado, usted debe notificar a su empleador o su aseguradora de cualquier salario ganado, cambio de empleo o condición médica, recibir beneficios de seguro por desempleo, recibir beneficios del Seguro Social y recibir beneficios de retiro. Si usted recibe beneficios por mas de 30 días, usted será requerido a certificar sus ganancias a su asegurador trimestralmente.

Está fuera de la ley que usted reciba beneficios de indemnización por incapacidad de compensación laboral y beneficios por desempleo al mismo tiempo, excepto por beneficios por incapacidad parcial permanente. Beneficios por incapacidad parcial permanente son aquellos pagados solamente por amputación o por perdida anatómica del uso de una de las partes del cuerpo o función. Si usted viola esta provisión, usted puede ser multado hasta con $10,000, o encarcelamiento hasta por 90 días, o ambas cosas.

Está fuera de la ley que usted a sabiendas haga, o ayude o aconseje a alguien el hacer, un falso testimonio o representación en orden de obtener o de aprovecharse de los beneficios de la compensación laboral. Si usted viola estas provisiones, usted debe ser multado, encarcelado o ambos, como sigue:

Beneficios pagados O reclamados fuera de ley	**Mulas**	**Encarcelamiento**
$10,000 o más	hasta $10,000	hasta 10 años, con o sin trabajos forzados
$2,500 o más pero menos de $10,000	hasta $5,000	hasta 5 años, con o sin trabajos forzados
menos de $2,500	hasta $500	hasta 6 meses

Además de estos cargos criminales, a usted se le puede fijar una penalidad civil hasta por $5,000 y puede perder el derecho de recibir beneficios de compensación laboral.

CERTIFICACION DEL EMPLEADO

Yo certifico que entiendo el contenido de este documento en su totalidad, y entiendo que yo soy responsable por esta información. Yo certifico estar de acuerdo con los requerimientos arriba detallados de los beneficios del plan de compensación raboral.

_____	_____	_____
Nombre en Molde Firma	Número de Seguro Social	Fecha

_____	_____	_____	_____
Dirección	Ciudad	Estado/C.Postal	Teléfono

Nota: Solamente una copia es requerida por caso de parte del empleado.

LDOL-WC 1025.EE
Revisada 12/2000

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.

It is 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 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 Name	- - Employee Social Security Number

LWC-WC-1025.ER
REV. 7/08

NOTICE
TO INJURED WORKERS

YOU HAVE THE RIGHT TO CHOOSE YOUR OWN DOCTOR!

WHEN YOU ARE INJURED AT WORK OR BECOME SICK BECAUSE OF SOMETHING THAT HAPPENED AT WORK, THE LAW GIVES YOU THE RIGHT TO CHOOSE YOUR OWN DOCTOR IN ANY FIELD OR SPECIALTY OF MEDICINE FOR MEDICAL TREATMENT.

THE LAW ALSO ALLOWS YOUR EMPLOYER TO HAVE YOU SEE HIS/HER DOCTOR, BUT YOU DO NOT HAVE TO AGREE TO CONTINUE TREATMENT WITH YOUR EMPLOYER'S DOCTOR UNLESS THAT IS WHAT YOU WANT.

IF YOU WANT YOUR EMPLOYER'S DOCTOR TO CONTINUE TREATING YOU AFTER YOUR FIRST VISIT WITH HIM/HER, AND AFTER RECEIVING THIS FORM, YOU MAY CHOOSE YOUR EMPLOYER'S DOCTOR AS YOUR TREATING DOCTOR.

ONCE YOU CHOOSE EITHER YOUR EMPLOYER'S DOCTOR OR YOUR OWN DOCTOR AS YOUR TREATING DOCTOR, YOU MAY NOT BE PERMITTED TO CHOOSE ANOTHER DOCTOR IN THAT SAME FIELD OR SPECIALTY OF MEDICINE TO TREAT YOU FOR YOUR INJURY OR ILLNESS LATER ON. HOWEVER, YOU ARE NOT REQUIRED TO GET YOUR EMPLOYER'S APPROVAL TO CHANGE TO A DOCTOR IN ANOTHER FIELD OR SPECIALTY OF MEDICINE (La. R.S. 23:1121(B)(1).

IF YOUR EMPLOYER DENIES YOUR RIGHT TO CHOOSE YOUR DOCTOR, YOU HAVE A RIGHT TO A SPEEDY HEARING BEFORE A WORKERS' COMPENSATION JUDGE TO RESOLVE THE DENIAL OF YOUR RIGHT (La. R.S. 23 1121 (B)(1) and 1124 (B).

I HEREBY CHOOSE MY OWN DOCTOR TO TREAT ME FOR MY INJURY OR ILLNESS:
DR. _____.

OR

BY SIGNING THIS FORM, I STATE THAT I KNOW ABOUT MY RIGHT TO CHOOSE MY OWN TREATING DOCTOR, AND BEING SO ADVISED, I HEREBY ACCEPT AND CHOOSE TO CONTINUE TREATING WITH MY EMPLOYER'S DOCTOR:
DR. _____.

_____ _____
DATE **SIGNATURE OF EMPLOYEE**

_____ _____
DATE **SIGNATURE OF EMPLOYER REPRESENTATIVE**

(Note: If the employee is illiterate or has a language barrier, an authorized representative of the employer/insurer shall attest by their signature that this form and right of physician choice has been reasonably explained to that employee prior to his/her signature on this form. Failure to do so can jeopardize the employer's/insurer's right to subsequently refuse consent to the employee's request for treatment by a different physician within the same field or specialty.)

(Form LWC – WC 1121)

EMPLOYEE'S MONTHLY REPORT OF EARNINGS

You must submit this report to your employer's workers' compensation insurer within 30 days of your job-related injury, and every 30 days as long as you receive workers' compensation indemnity benefits. You do not have to submit this report if you have only received medical benefits. Your workers' compensation benefits may be suspended if you do not timely submit this report.

Warning: Per L.R.S. 23:1208 of the Louisiana Workers' Compensation Statute, it shall be unlawful for a person, for the purpose of obtaining or defeating any benefit payment under the provisions of this Chapter, either for himself or for any other person, to willfully make a false statement or representation. Penalties for violations include imprisonment, fines, and/or the forfeiture of benefits.

DO NOT leave any blanks on this report. Print or type all responses, and use Not Applicable (N/A) or Zero (0) where appropriate.

1. The information in this report is true for the period beginning _____, 20___ and ending _____, 20 ____.

2. For the period covered in this report, did you receive a salary, wage, sales commission, or payment, including cash, of any kind? ☐ Yes ☐ No

   If yes, give name and address of employer _____
   If yes, give your gross earnings_____

3. For the period covered in this report, were you self-employed or involved in any business enterprise? **These include but are not limited to** farming, sales work, operating a business (even if the business lost money), child care, yard work, mechanical work, or any type of family business. ☐ Yes ☐ No

   If yes, describe the type of business you are involved in, your job duties, and the amount of income received from the business. _____
   _____

4. Did you perform any volunteer work during the period covered in this report? ☐ Yes ☐ No

   If yes, describe the type of volunteer work you performed. _____

5. Did you receive any unemployment insurance benefits for the period covered in this report? ☐ Yes ☐ No

   If yes, how much? _____ For how many weeks? _____

6. Did you receive any old age insurance benefits under Title II of the Social Security Act? ☐ Yes ☐ No

   If yes, how much? _____

7. Did you receive any Social Security Disability Benefits, retirement benefits, or any other type of disability or government benefits? ☐ Yes ☐ No

   If yes, how much? _____ What type of benefits did you receive? _____

Employee Certification

I certify that I understand the contents of this entire document and understand I am held responsible for this information. I certify my answers are complete and true, and certify my compliance with the Louisiana Workers' Compensation Act.

_____	_____
Print Name Signature	Social Security Number Date
_____	_____(_____) _____
Physical/Street Address City State/Zip	Telephone Number
_____	_____(_____)_____
Date of Injury Claim Number	Insurer Telephone Number

REPORTE MENSUAL DE GANANCIAS DEL EMPLEADO

Usted debe presentar este reporte a su asegurador de compensación laboral dentro de los próximos 30 días de la lesión por accidente-laboral, y cada 30 días por el tiempo que usted reciba beneficios de indemnización de compensación laboral. Usted no tiene que presentar este reporte si usted solamente recibe beneficios médicos. Sus beneficios de compensación laboral pueden ser suspendidos si usted no somete a tiempo este reporte.

Advertencia: Por el estatuto LA.R.S.23:1208 de la Compensación Laboral de Louisiana, debe estar fuera de la ley el que una persona, con el propósito de obtener o aprovechar cualquier beneficio de pago bajo la condición de este capítulo, ya sea para sí mismo o para cualquier otra persona, que voluntariamente haga una falsa declaración o representación. Penalidades por violaciones incluye encarcelamiento, multas, y/o pérdida de beneficios.

NO DEJE ningún espacio en blanco en este reporte. Escriba en letra de molde o a máquina todas las respuestas, y use No Aplica (N/A) o Zero (-0-) donde sea apropiado.

1. La información en este reporte es verdadera por el período que comienza_____, 20__ y termina_____, 20__.

2. Por el período cubierto en este reporte, usted recibió un salario, sueldo, comisiones por ventas, o pagos, incluyendo efectivo, de cualquier tipo?
   ___ Yes ___ No

   Si su respuesta es Sí, dé el nombre y dirección del empleador _____
   _____
   Si su respuesta es Sí, dé la cantidad total de sus ganancias_____

3. Por el período que cubre este reporte, usted trabajó por su cuenta o involucrado en cualquier negocio o empresa? **Estas incluidas pero no limitadas a** cultivo de la tierra, ventas, manejo de un negocio (aún y cuando el negocio perdió dinero), cuidado de niños, trabajos de jardineria, trabajo mecánico, o cualquier tipo de negocio familiar. ____ Sí ____ No

   Si su respuesta es Sí, describa el tipo de negocio en el que usted está involucrado, sus responsabilidades en el trabajo, y la cantidad recibida de este negocio.
   _____

4. Usted realizó cualquier trabajo voluntario durante el período que cubre este reporte? ___ Sí ___ No

   Si su respuesta es sí, describa el tipo de trabajo voluntario que realizó._____

5. Recibió usted cualquier cantidad en *beneficios del seguro por desempleo para el período que cubre este reporte? ___ Sí ___ No

   Si su respuesta es sí, cuanto fué? _____ por cuantas semanas? _____
   ***Por R.S.23:1225(B) No se deberá pagar ningún beneficio compensatorios por incapacidad temporal o permanente o beneficios ganados suplementalmente bajo este capítulo por cualquier semana en la cual el empleado ha recibido beneficios de compensación por desempleo.**

6. Recibió usted cualquier beneficio de seguro por vejez bajo el título II del Acta del Seguro Social? ___ Sí ___ No

   Si su respuesta es sí, cuanto? _____

7. Recibió usted cualquier beneficio de incapacidad del Seguro Social, beneficios de retiro, o cualquier otro tipo de incapacidad o beneficios del gobierno? ___ Sí ___ No

   Si su respuesta es sí, cuanto? _____ Que tipo de beneficios recibió usted __ _____

Certificación del Empleado

Yo certifico que entiendo el contenido de este documento en su totalidad, y entiendo que yo soy responsable por esta información. Yo certifico que mis respuestas son completas y verdaderas, y certifico estar de acuerdo con el Acta de Compensación Laboral de Louisiana.

_____ _____

Nombre en Molde Firma Seguro Social Fecha

_____ _____(_____)_____

Dirección Calle Ciudad Estado/C/Postal Número de Teléfono

_____ _____(___)_____

Fecha de Lesión Número de Cuenta Aseguradora Número de teléfono

LWC-WC 1020