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EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
PO Box 30016, Lansing, MI 48909

An employer shall report immediately to the agency on Form WC-100 all injuries, including diseases, which arise out of and in the course of the employment, or on which a claim is made and result in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific losses. In case of death, an employer shall also immediately file an additional report on WC-106. See instructions on reverse side for filing/mailing procedures.

I. EMPLOYEE DATA

1. Social Security Number	2. Date of injury	3. Employee name (Last, First, MI)		
4. Address (Number & Street)		5. City	6. State	7. ZIP Code
8. Date of birth (MM/DD/YYYY)	10. Number of dependents		11. Telephone number	

12. Tax filing status: ☐ A. Single ☐ B. Single, Head of Household ☐ C. Married, Filing Joint ☐ D. Married, Filing Separate

II. EMPLOYER/CARRIER DATA

13. Employer name			14. Federal ID Number	
15. Injury location code	16. Mailing location code	17. UI number	18. Type of business (SIC/NAICS)	
19. Employer street address		20. City	21. State	22. ZIP code
23. Insurance company name (if employer not self-insured)			24. Insurance company telephone number (if known)	

III. INJURY/MEDICAL DATA

25. Last day worked	26. Date employee returned to work (if applicable)		27. Did employee die? ☐ Yes ☐ No	28. If yes, date of death
29. Injury city	30. Injury state	31. Injury county	32. Did injury occur on employer's premises? ☐ Yes ☐ No (If no, see item 53)	
33. Case number from OSHA/MIOSHA log	34. Time employee began work ☐ a.m. ☐ p.m.		35. Time of event ☐ a.m. ☐ p.m.	If time cannot be determined, check here ☐

36. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific.

37. How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet;" "Worker was sprayed with chlorine when gasket broke during replacement"

38. Describe the nature of injury or illness	39. Part of body directly affected by the injury or illness

40. What object or substance directly harmed the employee? Examples: concrete floor, chlorine, radial arm saw. If this question does not apply to the incident, leave it blank.

41. Name of physician or other health care professional	42. Was employee treated in an emergency room? ☐ Yes ☐ No	43. Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

44. If treatment was given away from the worksite, where was it given? (Include name, address, city, state and ZIP code of facility)

IV. OCCUPATION AND WAGE DATA

45. Date hired	46. Total gross weekly wage (highest 39 of 52)	47. Number of weeks used	48. Value of discontinued fringes
49. Occupation (Be specific)	50. Was employee a volunteer worker? ☐ Yes ☐ No	51. Was employee certified as vocationally handicapped? ☐ Yes ☐ No	
52. Date employer notified by employee	53. If temporary service agency, provide name/address of employer where injury occurred.		

V. PREPARER DATA

I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

54. Preparer's name (Please print or type)	55. Preparer's signature	56. Telephone number	57. Date prepared

Notice to employee: Questions or errors should be reported immediately to the individual listed above in space 54

If you are using this form as a replacement for the Form 301 to document the specifics of an injury or illness for purposes of compliance with the work-related injury and illness logging requirements, follow the instructions in Section A only.

If you are using this form to report a workers' compensation injury, follow the instructions in Section A and B.

Section A

This form can be used in lieu of the MIOSHA Form 301, *Injury and Illness Incident Report.* It is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* (Form 300) and the accompanying *Summary (*Form 300A*)*, these forms help the employer and MIOSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out questions 1-9, 27-28, 33-45 and 54-57.

According to Public Law of 1970 (P.L. 91-596) and Michigan Occupational Safety and Health Act 154, P.A. 1974, Part 11, Michigan Administrative Rule for Recording and Reporting of Injuries and Illnesses, you must keep this form on file for 5 years following the year to which it pertains. **DO NOT mail this form to the Workers' Disability Compensation Agency unless it meets the conditions listed below in Section B.**

Section B

You must complete all questions on this form if the injury or disease results in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific loss. The original form must be mailed to the Workers' Disability Compensation Agency, P.O. Box 30016, Lansing, MI 48909.

Authority: Workers' Disability Compensation Act, 408.31(1)(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631	LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

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EMPLOYEE'S REPORT OF CLAIM

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
P.O. Box 30016, Lansing, MI 48909

NOTE: A copy of this form will be sent to your employer and their workers' compensation insurance carrier. Do not submit any medical reports with this form.

1. Social Security Number	2. Date of Injury		3. Date of Birth (MM/DD/YYYY)	4. Employee Telephone Number	
5. Employee Name (Last, First, MI)			10. Employer Name		
6. Employee Street Address			11. Employer Street Address		
7. Employee City	8. State	9. ZIP Code	12. Employer City	13. State	14. ZIP Code
15. Describe the type of injury and explain how it happened.					
16. Are you making a claim for payment of medical expenses? ☐ Yes ☐ No			17. Last Day Worked		
18. Have you gone back to work? ☐ Yes ☐ No If yes, date of return _____			19. Was the injury reported to your employer? ☐ Yes ☐ No If yes, date reported _____		

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

20. Employee Signature	21. Date of this report

OFFICE USE ONLY
Carrier Name

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	Authority: Workers' Disability Compensation Act, 408.31(4) Completion: Voluntary Penalty: None

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SUPPLEMENTAL REPORT OF FATAL INJURY

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
PO Box 30016, Lansing, MI 48909

THIS REPORT IS TO BE FILED BY THE EMPLOYER IMMEDIATELY AFTER THE DEATH OF AN INJURED EMPLOYEE.

I. DECEASED EMPLOYEE

1. Social Security Number	2. Date of Injury	3. Date of Death	
4. Name (Last, First, Middle Initial)			
5. Street Address	6. City	7. State	8. ZIP Code

II. EMPLOYER DATA

9. Employer Name		10. Federal I.D. Number	
11. Street Address	12. City	13. State	14. ZIP Code
15. Amount of Burial Expenses Paid (If Not Previously Reported) $			

III. DEPENDENTS OF EMPLOYEE

16. Name	17. Date of Birth	18. Relationship to Deceased (Spouse, Child, or Other - Please Specify Other)	19. Extent of Dependency (Total/Partial)

20. Employer's Signature	21. Title	22. Date

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Workers' Disability Compensation Act, R408.31(3)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act 418.631