## **EMPLOYER'S BASIC REPORT OF INJURY**

Michigan Department of Labor & Economic Growth Workers' 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)	9. Sex	10. Number of dependents	11. Telephone number	
	Male Female			
12. Tax filing status: A. Single	B. Single, Head of Household	d C. Married, Filing Joint	D. Married, Filing Separate	

II. EMPLOYER/CARRIER DATA					
13. Employer name			14. Federal ID Number	14. Federal ID Number	
15. Injury location code	16. Mailing location code	17. UI number	18. Type of business (S	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	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?	28. If yes, date of death
			Yes	No	
29. Injury city	30. Injury state	31. Injury county	32. Did injury occu	d injury occur on employer's premises?	
			Yes	No (If no, see iter	m 53)
33. Case number from OSHA/MIOSHA log		34. Time employee began work	35. Time of event		If time cannot be determined,
		a.m. p.m.		a.m. p.m.	check here
36. What was the employee doing ju	ust before the incident oc	curred? Describe the activity, as well as the to	ools, equipment, or m	naterial the employee	e was using. Be specific.
37. How did the injury occur? Exam	ples: "When ladder slippe	ed on wet floor, worker fell 20 feet;" "Worker wa	as sprayed with chlor	rine when gasket bro	oke 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.					
			40 14/4		
41. Name of physician or other heal	th care professional	42. Was employee treated in an emergency r	'oom? 43. was	employee nospitalize	ed overnight as an in-patient?
		Yes No		Ye	es 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 emplo	yee a volunteer worker?	51. Was employee certified as voo	cationally handicapped?
		Yes No	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 CERTIEV THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE				

#### **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' 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' Compensation Agency, P.O. Box 30016, Lansing, MI 48909.

Completion: Man	rkers' Disability Compensation Act, 408.31(1)(3) ndatory rkers' Disability Compensation Act, 418.631	The Department of Labor and Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.
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