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-1
EMPLOYER'S REPORT OF INDUSTRIAL INJURY

Instructions

The Employer's Report of Industrial Injury (WC-1) must be filed within seven (7) working days of the employee's notification of the injury to the employer.

Please ensure the information provided in the WC-1 is clear, legible, complete, and accurate. The WC-1 will be returned to the insurance carrier/adjuster if errors are encountered that will prevent the report from being entered into the Disability Compensation Division's Information System.

It is requested that all documents for Neighbor Island cases, including subpoena requests, be submitted to the respective island's District Office.

Pursuant to Section 386-95, Hawaii Revised Statutes (HRS), employers who fail to submit the WC-1 reports on a timely basis are subject to fines of up to $5,000.

Should you have any questions, please call your nearest Department of Labor and Industrial Relations Office.

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	

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

(Rev. 10/05)

IMPORTANT

THE *WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY* IS AN EMPLOYER'S REPORT TO THE HAWAII STATE DEPARTMENT OF LABOR AND INDUSTRIAL RELATION'S DISABILITY COMPENSATION DIVISION. THIS FORM MAY ALSO BE SUBSTITUTED AS AN EQUIVALENT FOR THE OSHA FORM 301 REPORTING REQUIREMENT. EVERY EMPLOYER MUST REPORT WITHIN 7 WORKING DAYS AFTER KNOWLEDGE OF SUCH INJURY CAUSING ABSENCE FROM WORK OF ONE DAY OR MORE, OR WHICH REQUIRES MEDICAL TREATMENT BEYOND FIRST AID.

COMPLETING THE WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

DO NOT MARK WITHIN THE SHADED BLOCKS (FOR DCD COMPUTER CODE ENTRY)

USE THE TAB KEY ON THE KEYBOARD TO MOVE THROUGH DOCUMENT

IDENTIFICATION SECTION (*MOVE CURSER OVER 'EMPLOYEE NAME LAST, FIRST, M.I.' TO VIEW WC-1 FORM)

*EMPLOYEE NAME LAST, FIRST, M.I.	Enter name shown on the employee's social security card (no nicknames). Jr, Sr, III, IV, etc should be placed after the first name for DCD computer input requirements.
SOC SEC NO	Enter employee's nine-digit social security number. If SSN is not provided, **WC-1 will be returned.**
DATE OF BIRTH	Enter employee's date of birth using the format, **mm/dd/yy,** to indicate the numerical month, day and year.
EMPLOYEE'S SEX AND MARITAL STATUS	Place an X in the appropriate box by using the enter or space bar key on the keyboard.
ADDRESS, ADDITIONAL ADDRESS, CITY, STATE, ZIP CODE	Enter employee's mailing address, c/o address in additional address field, city, state, and 5 digit zip code.
PHONE	Enter 10-digit area code and telephone number of employee.
OCCUPATION	Enter employee's job title.
DATE HIRED	Enter date employee was hired using the format, **mm/dd/yy,** to indicate the numerical month, day and year.
DEPARTMENT	Enter name of department employee was assigned at the time of injury or illness. Enter a brief description in the absence of formal department titles.
PAYROLL COMP CLASS CODE	If applicable, enter employee's rating manual occupation class code.
REGISTERED EMPLOYER	Enter name of employer exactly as it appears on the workers' compensation insurance policy or certificate of self-insurance.
DBA	If applicable, enter the 'dba' or 'doing business as' name of employer.
ADDRESS, CITY, STATE, ZIP CODE	Enter employer's address, city, state, and 5 digit zip code.
PHONE	Enter 10-digit area code and telephone number of employer.
NATURE OF BUSINESS	Enter principal type of business activity engaged in, i.e. restaurant, service station, contracting, auto repair shop
DATE INJURY/ILLNESS REPORTED	Enter date employer (management personnel) was informed of the injury or illness. Use the format, **mm/dd/yy,** to indicate the numerical month, day and year. If Date of Injury is not provided, **WC-1 will be returned.**
DATE OF INJURY/ILLNESS	Enter date of injury or illness or 'on or about' date if exact date is not known. Use the format, **mm/dd/yy,** to indicate the numerical month, day and year.

DOL NUMBER	Enter the 10-digit Department of Labor (DOL) account number. Use the same number as your Unemployment Insurance (UI) or Temporary Disability Insurance (TDI).
DETAIL OF INJURY/ILLNESS	
TIME OF INJURY/ILLNESS	Enter the AM or PM time of injury or illness using the format, **hh:mm,** to indicate the numerical hour and minute.
PLACE OF I/I IF DIFFERENT FROM EMPLOYER MAILING ADDRESS	Enter address or location description where injury/illness occurred. Fill in the city and state.
ON EMPLOYER'S PREMISES	Place an X in the appropriate box by using the enter or space bar key on the keyboard.
TIME WORKSHIFT BEGAN	Enter the AM or PM time of injury or illness using the format, **hh:mm,** to indicate the numerical hour and minute.
HOW DID THIS ACCIDENT OCCUR?	Describe the events that resulted in injury or occupational disease. What happened?
WHAT WAS EMPLOYEE DOING WHEN INJURED?	Describe employee's actions at time of injury or illness. Identify tools, equipment or materials being used.
OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE	Identify the object or chemical employee came into direct contact with or was using at the time of injury or illness.
DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF BODY AFFECTED	Describe the injury or illness fully and clearly, indicating the affected part of body or bodily system, i.e. amputation of right arm, crushing injury to chest, lead poisoning to respiratory system, dermatitis of right arm and hand.
TIME LOST INFORMATION	
DATE DISABILITY BEGAN	Enter date employee was disabled using the format, **mm/dd/yy,** to indicate the numerical month, day and year. If an employee is unable to complete his regular work shift because of a work injury, the employee shall be deemed totally disabled for that day. If the employee worked the scheduled hours on the day of the accident, enter the first day the employee was unable to work.
WAS EMPLOYEE FURNISHED MEALS OR LODGING?	Place a X in the appropriate box by using the enter or space bar key on the keyboard.
***AVG WKLY WAGE**	**Enter employee's numerical average weekly wage in whole numbers. If the average weekly wage includes cents, enter on right side of the median line.** **Use the following guidelines for the average weekly wage calculation:** 1. If an employee works a regular 40-hour workweek, and a. Is employed only at an hourly rate, multiply the hourly rate by 40. b. Is only on a pre-determined and fixed semi-monthly salary, multiply the semi-monthly salary by 24 (periods), then divide by 52 (weeks). c. Is only on a pre-determined and fixed monthly salary, multiply the monthly salary by 12 (months), then divide by 52 (weeks). 2. Computation of average weekly wages:

"Provided that where the employee holds part-time employment of fewer than thirty-five hours per week, the employee's average weekly wages shall be the hourly rate at the place of employment where the injury occurred multiplied by the average hours worked in the fifty-two weeks (or portions thereof) preceding the week in which the injury occurred, for the calculation of temporary partial disability and temporary total disability benefits only." (Section 386-51, HRS)

3. If an employee has had overtime earnings and/or bonuses which caused fluctuations in earnings, obtain the total earnings for the twelve months preceding the injury and divide by 52 weeks. If, however, because of sickness or other personal circumstances the employee did not work all of the 52 weeks, then use the number of weeks actually worked as the divisor instead of 52.

4. If an employee at the time of the injury was employed at a higher rate of pay than anytime during the twelve months preceding the injury, determine average weekly earnings solely on the higher rate of pay.
When an employee at the time of the injury was employed at higher wages than any other period in the preceding twelve months and had earned overtime pay during the twelve-month period, the average weekly wage is computed by adding the average weekly overtime earnings to the average weekly straight time pay. The average weekly overtime earning is obtained by:

    a. Dividing the total overtime hours worked during the 12-month period by 52, and

    b. Multiplying it by the overtime hourly rate (based on the higher wages) by the total number of straight time hours normally worked in a week.

5. If an employee is under 25 years of age and sustains an injury causing permanent disability or death, the average weekly wage shall be computed on the bases of the wages the employee would have earned had the employee been 25 years of age.

    a. If the employee is employed as an apprentice or trainee under the terms of an apprenticeship or on-the-job training program, average weekly wage shall be calculated on the basis of the rate of pay the employee would receive at age 25 under the apprenticeship or trainee agreement, plan, or contract. An apprenticeship or on-the-job training program is one which is registered with the Department of Labor and Industrial Relations, expressed in writing in a collective bargaining agreement or an employment contract, or one which the Director determines bears substantial similarities to that of an on-the-job or career training program based on a mutual employer-employee understanding.

    b. If the employee is not an apprentice or trainee, the average

	weekly wage shall be the median pay of the lowest and highest paid twenty-five year old employees employed in a similar occupation by the employer. If there are no twenty-five year old employees in a similar occupation with the same employer, obtain the median pay from twenty-five year olds in a similar occupation in employment with another employer in the State. * ***CONTACT THE DCD FOR ASSISTANCE IN DETERMING THE AVERAGE WEEKLY WAGE IN SITUATIONS WHERE THIS GUIDELINE DOES NOT PROVIDE ADEQUATE GUIDANCE.***
IF EMPLOYEE IS BACK TO WORK GIVE DATE	Enter date employee returned to work using the format, **mm/dd/yy,** to indicate the numerical month, day and year. If there is no lost time, enter date of injury.
WAS EMPLOYEE PAID IN FULL FOR DATE OF INJURY/ILLNESS	Place an X in the appropriate box by using the enter or space bar key on the keyboard.
IF EMPLOYEE DIED, GIVE DATE	If injury resulted in death, enter date employee died, using the format, **mm/dd/yy,** to indicate the numerical month, day and year.
GIVE NAME AND ADDRESS OF SURVIVORS ON BACK	If injury resulted in death of employee, the name and addresses of surviving spouse, minor dependent children, and/or other survivors should be listed on the back of this form. Attach marriage and death certificates if obtainable from dependents.
HOURLY WAGE	Enter employee's numerical hourly wage in whole numbers. If the hourly wage includes cents, enter on right side of the median line.
MONTHLY SALARY	Enter employee's numerical monthly salary in whole numbers. If the monthly salary includes cents, enter on right side of the median line.
HRS WKED/WK	Enter employee's numerical hours worked per week, in whole numbers. If the hours worked per week include a fraction, enter on right side of the median line.
TREATMENT	
NAME OF PHYSICIAN, ADDRESS	Enter name of treating physician and address.
NAME OF MEDICAL FACILITY	Enter name of medical facility and address.
INPATIENT OVERNIGHT?	Was employee hospitalized overnight as an in-patient? Place an X in the appropriate box by using the enter or space bar key on the keyboard.
EMERGENCY ROOM ONLY?	Was employee treated in an emergency room? Place an X in the appropriate box by using the enter or space bar key on the keyboard.
INSURANCE	
CARRIER I.D.	Self-explanatory.
NAME OF WC INSURANCE CARRIER	Enter name of the insurance carrier as it appears on the insurance policy. If employer is self-insured, enter "Self-Insured".
NAME OF ADJUSTING COMPANY	Third party administrator. If a general agent handles or administers the workers' compensation affairs for the insurance carrier, enter the full name of the agency in Hawaii.
IF LIABILITY DENIED - WHY?	If liability is denied or pending investigation, briefly state reasons for denial. If box is not checked, claim will be processed as liability accepted.
IS LIABILITY DENIED?	Place an X in the appropriate box by using the enter or space bar key on the keyboard
POLICY NO.	Enter insurance policy number.

POLICY PERIOD	Enter insurance policy period. The date of injury should be within the policy period.
ADJUSTER NAME	Name of person that adjusts the case.
CARR. CASE NO.	Enter the carrier's case number if you wish this number to appear on carrier's label.
ADJUSTER I.D.	Self-explanatory.
MEDICAL DEDUCTIBLE	Enter medical deductible figure. If no deductible, leave blank.
SIGNATURE	
SIGNATURE	Employer's authorized signature (not claimant's) required. If no signature, **WC-1 will be returned**.
TITLE	Title of authorized signatory.
DATE	Enter date document was signed using the format, **mm/dd/yy,** to indicate the numerical month, day and year.

Submit original and first copy of the WC-1 to DCD if the accident occurred on Oahu. If the accident occurred on a neighbor island, the original and first copy shall be sent to the appropriate district office of the Department of Labor and Industrial Relations. Please staple documents sent.

OAHU	**P.O. BOX 3769, HONOLULU, HAWAII 96813**	**PHONE: (808) 586-9161**
HAWAII	**75 AUPUNI STREET, HILO, HAWAII 96720**	**PHONE: (808) 974-6464**
WEST HAWAII	**P.O. BOX 49, KEALAKEKUA, HAWAII 96750**	**PHONE: (808) 322-4808**
MAUI	**2264 AUPUNI STREET, #2, WAILUKU, HAWAII 96793**	**PHONE: (808) 984-2072**
KAUAI	**3060 EIWA STREET #202, LIHUE, HAWAII 96766**	**PHONE: (808) 274-3351**

A copy of this report must be furnished to the injured employee.