ACORD™ WISCONSIN EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Avenue, Room 161
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
http://www.dwd.state.wi.us/WC

An employer subject to the provisions of ch. 102, Wis. Stats., shall within one day after the death of an employee due to a compensable injury, report the death to the Department of Workforce Development (DWD) and to the employer's insurance carrier, if insured. In cases of permanent disability or where temporary disability results beyond the 3-day waiting period, an insured employer shall also notify its insurance carrier of a compensable injury or illness within 7 days after the injury or beginning of a disability from occupational disease related to the employee's compensable injury.

Insurance carriers and self-insured employers must report all relevant information on this form for all compensable claims to DWD within 14 days of the date of the injury.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].
See instructions for completing this form on reverse side.

EMPLOYEE INFORMATION

Employee Name (First, Middle, Last)	Social Security Number	Sex	Employee Home Telephone Number
		☐ M ☐ F	

Employee Street Address	City	State	Zip Code	Occupation

Birth Date Month	Day	Year	Date of Hire	County and State where accident or exposure occurred

EMPLOYER INFORMATION

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured?	Nature of Business (Specific Product)
		☐ YES ☐ NO	

Employer Mailing Address	City	State	Zip Code	Employer FEIN

Name of Worker's Compensation Insurance Company or Self-Insured Employer	Insurer FEIN

Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer	TPA FEIN

WAGE INFORMATION

Wage at Time of Injury	Specify per hr., wk., mo., yr., etc.	In addition to Wages check boxes if Employee received:
		☐ Meals ____ No. of Meals per week
Is worker paid for overtime? If yes, after how many hours of work per week?		☐ Room ____ No. of Days per week
☐ YES ☐ NO		☐ Tips $ Average weekly amount

	Start Time	Hours per Day	Hours per Week	Days per Week
Employee's Work Schedule When Injured				
Employee's Normal Full-Time Schedule for Injured's Work				

For the 52 week period prior to the date the injury occurred, report the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.	Number of Weeks	Gross Amount Excluding Tips $	If Piece Work - No/Hrs. excluding overtime

Part-Time employment Information	Schedule Hours per Week	Are there other part time workers doing the same work with the same schedule? If yes, how many?	☐ YES ☐ NO	Number of full-time employees doing the same type of work.

INJURY INFORMATION

Date of Injury Month	Day	Year	Time of Injury	Last Day Worked Month	Day	Year	Date Employer Notified Month	Day	Year	☐ Date Returned to Work ☐ Estimated Date of Return	Month	Day	Year
			AM PM										

Was this a lost time or other compensable injury? ☐ YES ☐ NO If no, insurer does not submit report to DWD.

Did injury occur as a result of? ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Did injury cause death? ☐ YES ☐ NO

Name of Closest Dependent of Deceased if Injury Caused Death | Relationship

Address

Date of Death Month | Day | Year

Name of Witness

Name of Treating Practitioner and Hospital

Address of Treating Practitioner and Hospital

Injury Description - What happened to cause this injury or illness? Describe the employee's activities when the injury or illness occurred with details of how the event or exposure occurred. Include name(s) of other individuals involved. Specify tools, machinery, objects, chemicals, etc. that were involved in or caused the injury.

Report Prepared By	Work Phone No.	Position	Date Signed

WKC-12 (R. 2/98) **SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT**

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of the work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or third party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality.**

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of the work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee had multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed.

REMARKS