

**EMPLOYER REPORT  
 OF  
 INJURY / ILLNESS  
 LDOL-WC-1007**

Employee Social Security Number
Employer UI Account Number
Employer Federal ID Number
Location Code

**This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately. Forms for cases resulting in more than 7 days of disability or death are to be sent to the OWCA by the 10th day after the Incident or as requested by the OWCA.**

PURPOSE OF REPORT: (Check all that apply)

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> More than 7 days of disability | <input type="checkbox"/> Possible dispute               | <input type="checkbox"/> Medical Only |
| <input type="checkbox"/> Injury resulted in death       | <input type="checkbox"/> Lump Sum Compromise/Settlement | (no copy needed by OWCA)              |
| <input type="checkbox"/> Amputation or disfigurement    | <input type="checkbox"/> Other                          |                                       |

1. Date of Report MM/DD/YY	2. Date / time of injury: MM/DD/YY Time <input type="checkbox"/> AM <input type="checkbox"/> PM	3. Normal Starting Time Day of Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM	4. If Back to Work Give Date MM/DD/YY	5. At same Wage? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>DO NOT WRITE IN THIS COLUMN</b>
6. If Fatal injury, Give Date of Death: MM/DD/YY	7. Date Employer Knew of injury: MM/DD/YY	8. Date Disability began: MM/DD/YY	9. Last Full Day Paid MM/DD/YY	Date Received	
10. Employee Name: First Middle Last			11. <input type="checkbox"/> Male <input type="checkbox"/> Female	12. Employee Phone #  ( ) -	S.I.C.
13. Address and Zip Code			14. Parish of Injury	State-Parish	
15. Date of Hire	16. Age at illness/injury	17. Occupation	18. Dept./Division Employed:	Occupation	
19. Place of Injury-Employer's Premises ? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. If No, indicate Location-Street, City, Parish and State			Nature
21. What work activity was the employee doing when the incident occurred ? (Give weight, size and shape of material or equipment involved. Tell what he was doing with them. Indicate if correct procedures were followed.)					Part of Body
					Source
					Event
					NCC:
22. What caused the incident to happen? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)					
23. Part of body injured and Nature of Injury or Illness(ex. left leg: multiple fractures)				24. If Occ. Disease- Give Date Diagnosed	
25. Physician and Address street city state zip			26. If Hospitalized, give name & address of facility		
27. Employer's Name			28. Person Completing This Report – Please print		
29. Employer's Address street city state zip			30. Employer's Telephone Number  ( ) -		
31. Employer's Mailing Address – If Different From Above city state zip			32. Nature of Business – Type of Mfg., Trade, Construction, Service, etc.		
33. Wage Information Employee was paid <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other The average weekly wage was \$ per week.					
34. Verification of Employer Knowledge of this Report. Name: Title: Date:				<b>OFFICE OF RISK MANAGEMENT</b> P.O. Box 91106 Baton Rouge, LA 70821-9106 Phone No. (225) 219-0168	
DA 1973 R 8/98					

**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 I 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 I 0 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 can read the English language, 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 "Electronically signed by":

Date

Company Name

Company Address

(       ) -

Phone Number

Insurance Policy Number

-       -

Employee Name

Employee Social Security Number