Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a \$5,000 fine. (Sec. 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured employee a copy of this report.

	WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY								CASE NUMBER				
IDENTIFICATION S	ECTION				E IN SH	IN SHADED BLOCKS							
EMPLOYEE NAME - LAST	'	FIRST	M	.I. SOCS	EC NO		DATE O	F BIRTH	SEX	MARITAL ST.		RECEIVED	
							MM / D	DD /YY	MAL EMALE		,	DD /YY	
ADDRESS			ADDITION	IAL ADDRES	S INFORMATI	ON (C/O)	I WIWI / L	CITY				CODE	
PHONE	OCCUPATION		DATE HIRED	YF	RS EMP'D COI	DE DEPAR	RTMENT			PAYROLL COMP	OCC. CODE		
	0000.7111011		5/112/1111/25		10 2 5 00.	52.71	***************************************			CLASS CODE	000.0052		
			MM / DD /	YY									
REGISTERED EMPLOYER						DBA							
ADDRESS							CITY			S	TATE ZIP	CODE	
PHONE	NATURE OF BUSINESS		DATE INJ	URY/ILLNES	S REPORTED	DATE O	F INJURY/ILLNESS	S PREF	AB	DOL NU	IMBER	DBA	
					/ / / /								
	MM / DD / YY   MM / DD / YY   Wc-2												
DETAIL OF INJURY	/ ILLNESS												
TIME OF INJURY/ILLNESS	TIME OF I/I	PLACE OF I	I IF DIFFERENT FROM E	MPLOYER'S	MAILING ADD	RESS	CITY		STATE	ON EMPLOYER PREMISES	R'S INDUSTRIAL	CODE	
	1   1	1								YES N	0		
HOW DID THIS ACCIDENT OCC				ational dise	ease.		<u> </u>	SO	URCE OF INJU		VENT		
	Tell what happene	d. Please use separat	e sheet if necessary)			TIM	IE WORKSHIFT	BEGAN					
AM PM								PM					
WILLT WAS EMPLOYEE BOILE	WILLIAM BUILDED? (Disease	a ba anasifia Idantifi t	anda anuinmantar ma	starial tha					TASK	ACTIVITY	/ ACCIDE	NT FACTOR	
WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using)									TASK	ACTIVIT	r ACCIDE	NIFACTOR	
											AOS		
OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him; the vapor or poison inhaled or swallowed;  the chamical that irritated his skip. In cases of strains, the thing he was lifting pulling, etc.)													
the chemical that irritated his skin. In cases of strains, the thing he was lifting, pulling, etc.)													
DESCRIBE IN DETAIL THE NAT	URE OF THE INJURY, ILLNE	SS AND PART OF THE BO	DY AFFECTED						YES N	O NATURE OF I	NJURY PAR	T OF BODY	
					DISFIGU				VT 🔲	<b>□</b>			
								BURNS		]			
TIME LOST INFORMATION													
	AS EMPLOYEE FURNISHED	AVG WKLY WAGE	IF EMPLOYEE IS BACK		EMPLOYEE F		EMPLOYEE DIED	GIVE DATE HO	DURLY WAGE	MONTHLY SALARY	HRS WKED / W	/K WEIGHING FACTOR	
, ,	MEALS OR LODGING	1	WORK GIVE DATE	ILLNI	ESS			,	1	,		FACTOR	
MM / DD / YY	YES NO		MM / DD /	YY	LL YES	□NO (	MM / DD	DDRESS OF SUE	EVIVORS ON P	ACK ACK			
TREATMENT OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE													
NAME OF PHYSICIAN			ADDRI	ESS						PHYSICIAN	IS I.D. CODE		
NAME OF MEDICAL FACILITY ADDRESS												YES NO	
											T OVERNIGHT?	YES NO	
	Tourney 15									EMERGEN	ICY ROOM ONLY?		
	CARRIER I.D.												
INSURANCE	DDIED	NAME OF ARRIVATOR	POMPANY		IE I IABU :== :	ENIES ::	11/2					V.DE.V.===	
NAME OF WC INSURANCE CARRIER NAME OF ADJUSTING COMPANY IF LIABILITY DENIED — WHY?											IS LIABILIT		
										YES NO			
POLICY NO. POLICY PERIOD				ADJUSTER NAME					CARR	CARRIER CASE NO.			
	I .				-1		ADJUSTER I.D.		MEDIC	CAL DEDUCTIBLE			
SIGNATURE													
3.0					Т	ITLE					DATE		
												,	
											/	DD / YY	

(REV. NOV/01)