must be reported \$5,000 fine. (Se	y to an employee caused within 7 working dates a within 7 working dates a safe-95, H.R.S. No VERED FULLY TO AN	ys after the injury	 Failure to SION IMME 	o report prom DIATELY IF	ptly is a mis	sdemeanor	punishable by	/ not more	than a	to	e law require furnish the in opy of this re	njured emj		
IDENTIFICATION SECTION NOTE: DO NOT WRITE IN SHADED BLOCKS											CASE NUMBER			
IDENTIFICATI		FIRST	OTE: DO	NOT WRI	SOC SEC NO			FBIRTH	SEX -		ARITAL STATUS	DATE REC		
EMPLOTEE NAME - LAST FIRST			S1 M.I.					MALE		J ,				
ADDRESS			ADDITIO	NAL ADDRESS IN	FORMATION (C	:/O)	MM / [D / YY CITY	FEMALE L	<u> </u>	STATE	MM / DD ZIP CC		
PHONE	OCCUPATION			HIRED	YRS EMP'I		RTMENT			DA	YROLL COMP	OCC. CODE		
FILONE				5,112,111,125		CODE				Ċ	CLASS CODE	OCC. CODE	ICC. CODE	
REGISTERED EMPLOY	YER		мм /	DD / YY		DBA								
ADDRESS							CIT	(STATE	ZIP CODE		
PHONE	NATURE OF BUSINESS			DATE INJURY/ILLNES REF				SS PREFAB			DOL NUMBE	B	DBA	
PHONE				JATE INJURT/ILLINES REPORTED DATE OF INJURT/			INJUR F/ILLINESS	(TILLINESS FREFAD			DOL NUMBE	.r.	DBA	
				MM / DD	/ үү	мм /	dd / yy	WC-2	WC-5					
DETAIL OF IN	JURY / ILLNESS	1	ľ											
TIME OF INJURY/ILLNE	ESS TIME OF I/I O	ODE PLACE	OF I/I IF DIFFERI	ENT FROM EMPLO	DYER'S MAILIN	G ADDRESS	CITY		STATE	•	ON EMPLOYER'S PREMISES	INDUSTRIAL	CODE	
AM	_рм									C	YES NO			
HOW DID THIS ACCIDE	ENT OCCUR? (Please desc Tell what hap	ribe fully the events that pened. Please use se	at resulted in inj parate sheet if	jury or occupatior necessary)	al disease.	TIME	WORKSHIFT BEG	AN	SOURCE OF I	NJURY	EV	ENT		
							AM	PM						
		(0)							TAOK				FLOTOD	
WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using) TASK											ACTIVITY	ACCIDENT	FACTOR	
											AC	S		
OBJECT OR SUBSTAN	ICE THAT DIRECTLY INJUR						r poison inhaled o bject employee wa		na etc.)					
				ou employee a a			bjeet employee we	in inting, puini	ig, etc.)					
DESCRIBE IN DETAI	IL THE NATURE OF THE	INJURY, ILLNESS AN	ID PART OF THE	E BODY AFFECTE	D									
								NATURE OF INJUR	Y PART C	F BODY				
								BURNS						
	FORMATION													
DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISH MEALS OR LODGING?	IED AVG WKLY WAG	E IF EMPL WC	LOYEE IS BACK TO IRK GIVE DATE	WAS EMPLOYE FOR DAY OF IN	EE PAID IN FULL JURY/ ILLNESS?	IF EMPLOYEE DIED GIV	E DATE HOU	IRLY WAGE	MONTHLY S	ALARY HRS W	KED / WK	WEIGHING FACTOR	
MM / DD / YY		b	ММ	/ DD / YY	YES	NO 🛛	MM / DD /	YY						
		TING PHYSICIAN FROM E		,,					URVIVORS ON BA	CK				
TREATMENT				ADDRESS							PHYSICIAN I.D.	CODE		
NAME OF MEDICAL FACILITY			ADDRESS							INPATIENT OVERNIGHT?				
	CARRIER I.D.										EMERGENCY R	DOM ONLY?		
NSURANCE	1													
NAME OF WC INSURANCE CARRIER NAME OF ADJUSTING COMPANY					IF LIABILITY DENIED – WHY?							S LIABILITY DE	NIED?	
POLICY NO. POLICY PERIOD					1] _{YES}	NO	
		DLICY PERIOD	CY PERIOD			ADJUSTER NAME								
		-					ADJUSTER	: I.D.		N	MEDICAL DEDUCTIBL	E		
SIGNATURE]													
						TITLE						DATE		
												MM / DD	/ YY	

WC-1 (Rev. SEPT/16)