This form must be printed and sent to the NH Department of Labor and your insurance carrier.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

NH DOL USE ONLY

Return to: **The State of New Hampshire, Department of Labor**
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

IMPORTANT; *Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

1. Name of injured: First Middle Initial Last
2. DOB:
3. Age:
4. Male _ _ Female _ _
5. SS No.:
6. Address: No. & St. City/Town
7. State:
8. Zip Code:
9. Tel. No.:
10. Is there on file a N.H. Youth Employment Certificate?:
11. Occupation when injured:
12. Was this his/her regular occupation? If not, state regular occupation:
13. Wages per hr.:
14. No. hrs. worked per day:
15. No. days worked per week:
16. Average Weekly Earnings:
17. Was injured hired in N.H.?
18. Date employment began:
19. Date & Time of Injury:
20. Date disability began:
21. Was injured paid in full for this day?
22. Date supervisor/employer was first notified:
23. Name of Person notified:
24. Location/Jobsite where accident occured:
25. Describe fully how accident occurred and describe what employee was doing when injured:
26. Name of witness(es):
27. Part(s) of body injured:
28. Estimated length of disability:
29. Has injured returned to work?
30. If so, what date?
31. At what occupation or job?
32. Returned at: Full Duty: ____ ____ Alternative/Light Duty: ____ ____
33. Equipment causing injury:
34. Were safeguards in place?
35. Was accident caused by injured's failure to use safeguards or follow regulations?
36. Initial Treatment: (check those that apply) No medical treatment: _ _ Care provide by Employer only (on-site): _ _ Emergency care: _ _ Hospitalized: _ _
Other: (Outpatient): _ _ (Clinic): _ _ (Office Visit): _ _ (Other-explain): _____
37. Name of treating physician: Name of treating hospital:
38. Has injured died? If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name:
40. Employers Federal ID:
41. If leased or temporary worker, client's business name:
42. Business Address of No. 39 above:
43. City/State:
44. Zip:
45. Telephone Number:
46. Insurance Co. (**not agent**) or Self Insured Group:
47. Managed Care Program? Y or N. If yes, name Provider:
48. No. of Employees: Full-time: Part-time:
49. Is there a Written Safety Program **in force**?
50. Is there an **active** Safety Committee?
51. Business SIC Code
52. Type or Nature of Business in N.H.:
53. If report sent by Insurance Agency, state name:
54. Employer Signature:
55. Printed/Typed Name and Official Title:
56. Employee Signature (**whenever** possible):
57. Date of this report:

This form must be printed and sent to the NH Department of Labor and your insurance carrier.

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
SPAULDING BUILDING
95 PLEASANT STREET
CONCORD, NEW HAMPSHIRE

NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE 8aWCA

(Please print or type)

To_____ Phone #_____
(Name of **Employer**)

_____
(Business Name and Address)

IN ACCORDANCE WITH RSA 281-A:20, This is to notify you that an injury occurred.

_____ SS #_____
(Name of Injured **Employee**)

_____Daytime Phone #_____
(Address of Injured Employee)

_____
(Date of Accident or First Treatment)

_____
(Place Accident Happened)

Describe your injury or disease, and how it happened. Identify the body part(s) affected._____

_____

_____

_____

I have been unable to work since my injury. ☐ Yes ☐ No

I have incurred the following medical bills.

_____ Name of Doctor	_____ - _____ Dates of Service	_____ Amount
_____ Name of Hospital	_____ - _____ Dates of Service	_____ Amount
_____ Other	_____ - _____ Dates of Service	_____ Amount

_____ **(Employer's Signature)**

_____ **(Employee's Signature)**

_____ **(Date)**

_____ **(Date)**

This form can be returned to DOL with or without employer's signature.

NOTICE TO EMPLOYER

YOU MUST FILE AN EMPLOYER'S FIRST REPORT, Form No. 8WC, WITH THE LABOR COMMISSIONER AND THE NEAREST CLAIMS OFFICE OF YOUR INSURANCE CARRIER, AS SOON AS POSSIBLE AFTER ACQUIRING KNOWLEDGE OF THE OCCURRENCE OF AN OCCUPATIONAL INJURY OR DISEASE TO ONE OF YOUR EMPLOYEES OR UPON PRESENTATION OF THIS NOTICE BY HIM, BUT NO LATER THAN FIVE DAYS THEREAFTER. FAILURE TO COMPLY CARRIES AN AUTOMATIC CIVIL PENALTY OF UP TO $2500. (RSA 281-A:53)

NEW HAMPSHIRE WORKERS' COMPENSATION MEDICAL FORM

This form must be completed at each health professional visit (MD, DO, DC or DDS) and must be filed with the worker's compensation insurance carrier within 10 days of the treatment (first aid excluded). Failure to comply and complete this form shall result in the provider not being reimbursed for services rendered and may result in a civil penalty of up to $2,500.

In compliance with RSA 281-A:23-b, the employer with 5 or more employees must provide temporary alternative/transitional work opportunities to all employees temporarily disabled by a work related injury or illness.

Employee _____ Employer _____

SS # _____ Work telephone # _____

Occupation _____ Employer contact _____

Date last worked _____ Employer address _____

W.C. insurer _____ _____

HEALTH PROFESSIONAL TO COMPLETE

☐ Initial visit ☐ Follow-up visit Date of injury _____ Time _____

Worker's statement of the incident _____

Worker's complaints _____

Diagnosis/Prognosis _____

Treatment plan _____

_____

In your opinion is this injury and disability as a result of injury described above? ☐ Yes ☐ No ☐ Unclear

EMPLOYEE WORK CAPABILITY

☐ Continue Working Can return to work: ☐ Yes Date _____ ☐ No

☐ Full Duty ☐ With Modification. If so, for what duration? _____

Employee can	No Restrictions	Frequently	Occasionally	Unable to
bend				
kneel				
squat				
climb				
stand				
walk				
sit				
reach				
drive				
do fine motor				

No repetitive motions		Wrist	Elbow	Shoulder	Ankle
	Right				
	Left				

Employee can lift/carry maximally _____ lbs.
Employee can lift/carry frequently _____ lbs.

Employee can work a maximum of #___ hours/day, #___days /wk.
What special accommodations are required? _____
_____

Other _____
Has employee reached maximum medical improvement?
☐ Yes ☐ No
Has injury caused permanent impairment?
☐ Yes ☐ No ☐ Undetermined

ALL MEDICAL NOTES MUST BE ATTACHED TO BILL

I certify that the narrative descriptions of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of my knowledge.

_____ Provider's signature
_____ Provider's Printed name
_____ Provider's telephone#

_____ Federal ID#
_____ Date of visit

MEDICAL AUTHORIZATION: The act of the worker in applying for workers' compensation benefits constitutes authorization to any physician, hospital, chiropractor, or other medical vendor to supply all relevant medical information regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, and the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. [281-A:23 V(a)]

N.H. WORKERS' COMPENSATION TASK ANALYSIS

In compliance with RSA 281-A:23-b, the employer with 5 or more employees must provide temporary alternative/ transitional work opportunities to all employees temporarily disabled by a work-related injury or illness.

Task is defined as one of the distinct activities that constitute logical and necessary steps in the performance of a job. A *task analysis,* for the purpose of this section, is the evaluation of the physical requirements of each task of a particular job or work assignment.

Employer _____ Employee _____

Telephone # _____ W.C. Insurer _____

Employer Address _____

Complete the following information to describe the employee's job at the time of injury:

Job Title _____ Usual Job? Yes ___ No ____ General Description/Purpose _____

_____

Department _____ Supervisor _____

Description of Tasks (use additional page as needed):

1. _____

2. _____

3. _____

4. _____

5. _____

Tools & Equipment _____

Describe Special Demands _____

_____

PHYSICAL DEMANDS

Complete the following to show the *maximum* physical demand for all of the tasks listed above. For example, if Tasks 1 through 4 require no bending but Task #5 requires "occasional" bending, the overall job must be rated as requiring occasional bending.

JOB REQUIRES: part of day	Continuous 100%-67%	Frequent 66%-34%	Occasional 33%-1%
bending			
kneeling			
squatting			
climbing			
standing			
walking			
sitting			
reaching			
driving			
fine motor skills			

JOB REQUIRES:

maximum lifting/carrying of _____ lbs.

frequent lifting/carry of _____ lbs.

WORK SCHEDULE:

Number of hours/day _____

Number of days/week _____

Does job require Repetitive Motions? *(check if applicable)*				
	wrist	elbow	shoulder	ankle
Right				
Left				

ATTACH JOB DESCRIPTION IF AVAILABLE

_____ _____ _____

Completed by *Title* *Date*

N.H. WORKERS' COMPENSATION TASK ANALYSIS

In compliance with RSA 281-A:23-b, the employer with 5 or more employees must provide temporary alternative/ transitional work opportunities to all employees temporarily disabled by a work-related injury or illness.

Task is defined as one of the distinct activities that constitute logical and necessary steps in the performance of a job. A *task analysis,* for the purpose of this section, is the evaluation of the physical requirements of each task of a particular job or work assignment.

Employer _____ Employee _____

Telephone # _____ W.C. Insurer _____

Employer Address _____

Complete the following information to describe the employee's job at the time of injury:

Job Title _____ Usual Job? Yes ___ No ____ General Description/Purpose _____

_____

Department _____ Supervisor _____

Description of Tasks (use additional page as needed):

1. _____

2. _____

3. _____

4. _____

5. _____

Tools & Equipment _____

Describe Special Demands _____

_____

PHYSICAL DEMANDS

Complete the following to show the *maximum* physical demand for all of the tasks listed above. For example, if Tasks 1 through 4 require no bending but Task #5 requires "occasional" bending, the overall job must be rated as requiring occasional bending.

JOB REQUIRES: part of day	Continuous 100%-67%	Frequent 66%-34%	Occasional 33%-1%
bending			
kneeling			
squatting			
climbing			
standing			
walking			
sitting			
reaching			
driving			
fine motor skills			

JOB REQUIRES:

maximum lifting/carrying of _____ lbs.

frequent lifting/carry of _____ lbs.

WORK SCHEDULE:

Number of hours/day _____

Number of days/week _____

Does job require Repetitive Motions? *(check if applicable)*				
	wrist	elbow	shoulder	ankle
Right				
Left				

ATTACH JOB DESCRIPTION IF AVAILABLE

_____ _____ _____

Completed by *Title* *Date*

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

Employer's Supplemental Report of Injury

This report, indicating disability of an employee of four or more days, shall be filed as soon as possible after date of knowledge of an occupational injury or disease, but no later than ten days thereafter. Consistent failure to make this report available to the labor commissioner and the nearest claims office of your insurance carrier carries an automatic civil penalty of up to $100.00. (RSA 281-A:53) This report shall also be submitted upon employee's return to work.

1. Name of Employer _____ Employer's Identification No. _____
(9 digit number assigned by proper Federal Agency)

2. Address _____
(No. and St.) (City and State) (Zip Code)

3. Insured by _____

4. Name of Employee _____
(First Name) (Middle Initial) (Last Name) (S.S. Number)

5. Address _____
(No. and St.) (City and State) (Zip Code)

6. Date of injury _____ 19____

7. Date Disability began _____ 19____ A.M. _____ P.M. _____

8. _____
(Specific dates of disability)

_____
(Specific dates of disability)

9. Has injured returned to work? _____ if so, date and hour _____ A.M. _____ P.M. _____

10. Is injured person earning same wages as before injury? _____ If not, explain _____

_____

Date of Report _____

Signed by _____

Official Title _____

Tel. No. _____

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

CONCORD, N.H. 03301

SUPPLEMENTAL WAGE SCHEDULE

TO BE COMPLETED ONLY WHEN INDEMNITY RATE IS BASED ON AFTER-TAX EARNINGS AS DEFINED BY RSA 281-A:2, 1-a.

TOTAL NUMBER OF DEPENDENTS (INCLUDES EMPLOYEE) _____

FILING STATUS (MARRIED OR SINGLE) _____

List names and ages of all dependents

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

Average Weekly Wage _____ Line 1

Amount of Federal Withholding Tax to be Deducted using Figure from Line 1 _____ Line 2

FICA rate factor _____ Line 3

Multiply amount from Line 1 by FICA rate factor _____ Line 4

Total Deductions (Add Lines 2 and 4) _____ Line 5

AFTER-TAX EARNINGS INDEMNITY RATE (Subtract amount in Line 5 from amount in Line 1) _____ Line 6

_____ Signature – Employee

_____ Signature – Adjuster

_____ Date

_____ Date

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1 You are required by law (RSA 281-A:19) to report promptly to your employer an occupational injury or disease, even if you deem it to be minor. Form No. 8a WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A:20,21). After you have completed and made it available to him or her, your employer must acknowledge receipt by signing and giving you a copy.

2 You are entitled to the services of a physician. This physician shall be within a managed care network, if applicable under RSA 281-A:23a.

3 You may not sue your employer as a result of a work-connected injury or disease by reason of your eligibility for benefits under the Workers' Compensation Law.

TO EMPLOYERS

1 You are required to display this poster so that it will be of the greatest possible benefit to your employees (RSA 281-A:4).

2 You are required to file an Employer's First Report of Injury or Occupational Disease, form No. 8 WC, with the Labor Commissioner, copy to the nearest claims office of your insurance carrier, on all occupational injuries or diseases resulting in one visit to a physician, other than a house physician, as soon as possible but no later than five days after the date of knowledge thereof (RSA 281-A:53, I).

3 You are required to report to the Labor Commissioner, copy as in 2 above, any occupational disability, whether total or partial, of four or more days (RSA 281-A:22), on an Employer's Supplemental Report of Injury, form No. 13 WCA, as soon as possible, but no later than ten days after the date of knowledge thereof (RSA 281-A:53,I and II).

4 You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee in accordance with RSA 281-A:23, 25, 26, 28, 29, 31, 32.

5 All employers with 5 or more full time employees shall develop temporary alternative work opportunities for injured employees in accordance with RSA 281-A:23-b. Employers may be obligated to reinstate employees sustaining a compensable injury in accordance with RSA 281-A:25-a.

6 You are required to obtain from the carrier identified below a supply of all required workers' compensation forms. NOTICE – Violation of the various provisions of the Workers' Compensation Law carries civil penalties, court fines, or both.

David M. Wihby
Deputy Labor Commissioner

George N. Copadis
Labor Commissioner

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations of the Labor Commissioner of the State of New Hampshire pursuant to Revised Statutes Annotated, Chapter 281-A, as amended.

Name of Insurance Company
Or self-insurer:

Name of Employer:

By _____

_____
Employer Identification No.
(If number unknown, Employer to request from IRS)

This notice must be posted conspicuously in and about the Employer's place or places of business.

Prescribed by Labor Commissioner
State of New Hampshire
WCP-1 (1-99)

ESTADO DE NEW HAMPSHIRE
LEY DE COMPENSACIÓN PARA TRABAJADORES
AVISO DE LA CONFORMIDAD

A LOS EMPLEADOS

1 Cerca le requieren (RSA 281-A:19) divulgar puntualmente a su patrón lesión o una enfermedad ocupacional, incluso si usted la juzga para ser de menor importancia. Forme No. 8a WCA, aviso de lesión accidental o la enfermedad profesional, se puede utilizar para ese propósito (RSA 281-A:20,21). Después de que usted la haya terminado y haya puesto a disposición él o ella, su patrón debe recibo del acknowlege firmando y dándole una copia.
2 Le dan derecho a los servicios de un médico. Este médico estará dentro de una red manejada del cuidado, si RSA inferior aplicable 281-A:23a.
3 Usted no puede demandar a su patrón como resultado de lesión o de una enfermedad trabajar-conectada por causa de su elegibilidad para las ventajas debajo de Workers' Ley De la Remuneración.

A LOS PATRONES

1 Le requieren exhibir este cartel de modo que esté de la ventaja posible más grande a sus empleadso (RSA 281-A:4).
2 Le requieren archivar un informe de Employer's primer de lesión o de la enfermedad profesional, WC de la forma No. 8, con la comisión de trabajo, copia a la oficina más cercana de las demandas de su portador de seguro, en todas las lesiones o enfermedades ocupacionales dando por resultado una visita a un médico, con excepción de un médico de la casa, cuanto antes pero no más adelante de de cinco días después de la fecha del conocimiento (RSA 281-A:53i).
3 Le requieren divulgar a la comisión de trabajo, copia como en 2 arriba, cualquier inhabilidad ocupacional, si total o parcial, de cuatro o más días (RSA 281-A:22), en un informe suplemental de Employer's de lesión, forma No. 13 WCA, cuanto antes, pero no más adelante de diez días después de la fecha del conocimiento (RSA 281-A:53, i e II).
4 Le requieren equipar, o haga ser equipado, los servicios médicos y del hospital razonables, el otro cuidado remediador o los tipos vocacionales del rehabilitación, y varios de pensión por invalidez, a un empleado dañado o lisiado de acuerdo con RSA 281-A:23, 25, 26, 28, 29, 31, 32.
5 Todos los patrones con empleados 5 o más a tiempo completo desarrollarán las oportunidades alternativas temporales del trabajo para los empleados dañados de acuerdo con RSA 281-A:23-b. Los patrones pueden ser obligados reinstalar a empleados que sostienen lesión compensable de acuerdo con RSA 281-A:25-a.
6 Le requieren obtener del portador identificado debajo de una fuente de las formas de la remuneración de todos los trabajadores requeridos. AVISO - la violación de las varias provisiones de la ley de la remuneración de los trabajadores lleva penas, multas de la corte, o ambas civiles.

David M. Wihby
Diputado Labor Comisión

George N. Copadis
Comisión De trabajo

El patrón infrascrito da por este medio el aviso de la conformidad con todas las provisiones de la ley de la remuneración de los trabajadores y de las regulaciones administrativas de la comisión de trabajo del estado de New Hampshire conforme a los estatutos revisados anotados, capítulo 281-A, según la enmienda prevista.

Nombre de la compañía de seguros
O uno mismo-asegurador:

Nombre del patrón:

Por _____

_____
No. De la Identificación Del Patrón.
(si desconocido, patrón del número a solicitar el IRS)

Este aviso se debe fijar visible en y sobre el lugar de Employer's o los lugares del negocio
Prescrito por la comisión de trabajo
Estado de New Hampshire
WCP-1 (1-99)