☐ NEW
☐ AMEND

STATE OF HAWAII
DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY
NOTE: COMPLETE THE FILLABLE-DARK SHADED BLOCKS

CASE NUMBER
DATE RECEIVED

Every work injury/illness 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/illness. 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/ILLNESS RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

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

IDENTIFICATION - SECTION 1

EMPLOYEE NAME – LAST	FIRST	M.I.	SUFFIX

SEX/GENDER	MARITAL STATUS	IDENTIFICATION TYPE	IDENTIFICATION NUMBER	DATE OF BIRTH
☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED	☐ SSN ☐ PASSPORT		

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)

CITY	STATE	ZIP CODE	EMAIL ADDRESS

PHONE NUMBER	DATE HIRED	YEARS EMPLOYED CODE	OCCUPATION
( ) –			

DEPARTMENT	PAYROLL COMP CLASS CODE	SOC CODE	OCC CODE

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER POINT OF CONTACT	PHONE NUMBER	EMAIL ADDRESS
	( ) –	

NATURE OF BUSINESS	PRE-FABRICATED	DEPARTMENT OF LABOR NUMBER	FEDERAL ID NUMBER
	☐ WC-2 ☐ WC-5		

DETAIL OF INJURY/ILLNESS (I/I) - SECTION 2

DATE OF INJURY/ILLNESS REPORTED	DATE OF INJURY/ILLNESS	TIME OF I/I	TIME OF DAY	ON EMPLOYER'S PREMISE	DID EMPLOYEE WORK A FULL SHIFT?
			☐ AM ☐ PM	☐ NO ☐ YES	☐ NO ☐ YES

IF NOT ON EMPLOYER'S PREMISES, INDICATE PLACE WHERE INJURY/ILLNESS OCCURRED	CITY	STATE	ZIP CODE

A. HOW DID THIS INJURY/ILLNESS OCCUR? - Please describe fully the events that resulted in injury/illness or occupational disease. Explain what happened. Please continue in Supplemental Section if additional space is needed.

TIME WORK SHIFT BEGAN	TIME OF DAY	TIME WORK SHIFT END	TIME OF DAY	SOURCE OF INJURY/ILLNESS	EVENT
	☐ AM ☐ PM		☐ AM ☐ PM		

TASK	ACTIVITY	INJURY/ILLNESS FACTOR	AOS

B. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? - Please be specific. Identify tools, equipment, or material the employee was using. Please continue in Supplemental Section if additional space is needed.

C. 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 chemical that irritated employee's skin. In cases of strains, the object employee was lifting, pulling, etc. Please continue in Supplemental Section if additional space is needed.

CASE NUMBER

DETAIL OF INJURY/ILLNESS (I/I) - SECTION 2 (continued)

D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED - Please continue in Supplemental Section if additional space is needed.

MULTIPLE BODY PARTS?	NATURE OF INJURY/ILLNESS	PART OF BODY CODE
☐ NO ☐ YES		

#	SIDE OF INJURY/ILLNESS				PART OF BODY	DISFIGUREMENT		BURN	
1.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
2.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
3.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
4.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
5.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES

TIME LOST INFORMATION - SECTION 3

DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISHED MEALS, TIPS, OR LODGINGS?	AVERAGE WEEKLY WAGE	IF EMPLOYEE IS BACK TO WORK, GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS?
	☐ NO ☐ YES			☐ NO ☐ YES

IF EMPLOYEE DECEASED, GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS WORKED/WEEK	WEIGHING FACTOR

DECEDENT'S DEPENDENTS - SECTION 4

1.	DEPENDENT 1 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 1 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	
2.	DEPENDENT 2 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 2 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	
3.	DEPENDENT 3 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 3 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	
4.	DEPENDENT 4 – LAST NAME	FIRST NAME	M.I.	SUFFIX	RELATION TO DECEASED	
	DEPENDENT 4 - ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( ) -	

TREATMENT (OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE) - SECTION 5

NAME OF PHYSICIAN	PHONE NUMBER	EMAIL ADDRESS
	( ) -	

ADDRESS	CITY	STATE	ZIP CODE		NO	YES
				INPATIENT OVERNIGHT	☐	☐
				EMERGENCY ROOM ONLY?	☐	☐

NAME OF MEDICAL FACILITY	ADDRESS	CITY	STATE	ZIP CODE

INSURANCE CARRIER - SECTION 6

NAME OF WC INSURANCE CARRIER	CARRIER ID

IS LIABILITY DENIED?	IF LIABILITY DENIED, WHY?
☐ NO ☐ YES	

NAME OF ADJUSTING COMPANY	ADJUSTER NAME

EMAIL ADDRESS	PHONE NUMBER	ADJUSTER ID NUMBER
	( ) -	

POLICY NUMBER	POLICY PERIOD	MEDICAL DEDUCTIBLE	CARRIER CLAIM NUMBER
	FROM: TO:		

SIGNATURE - SECTION 7

SIGNATURE	TITLE	DATE

CASE NUMBER

SUPPLEMENTAL - SECTION 8

A. HOW DID THIS INJURY/ILLNESS OCCUR? (continued from Section 2.A)

B. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (continued from Section 2.B)

C. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (continued from Section 2.C)

D. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED (continued from Section 2.D)

ENGLISH	This document contains important information. If you need language assistance at no cost to you, please contact us by telephone or in person immediately.
ILOKANO	Daytoy nga dokumento ket addaan ti importante nga impormasyon. No masapul mo ti mangipatarus nga libre, pangngaasim ta awagan na kami ti telepono wenno umay na kami kitaen nga daras.
TAGALOG	Ang dokumentong ito ay naglalaman ng importanteng impormasyon. Kung nangangailangan kayo ng libreng tulong para maintindihan ito, mangyaring makipag-ugnay sa amin sa pamamagitan ng telepono o makipagkita kagaad sa amin.
CHINESE SIMPLIFIED	此文件有重要信息。如果您需要免费的语言协助服务，请您立刻给我们打电话或来我们办公室请求帮助。
CHINESE TRADITIONAL	此文件有重要信息。如果您需要免費的語言協助服務，請您立刻給我們打電話或來我們辦公室請求幫助。
SPANISH	Este documento contiene información importante. Si necesita los servicios de un intérprete sin costo alguno para usted, por favor llame de inmediato por teléfono o contacte con alguna persona de nuestra oficina.
JAPANESE	この書類には重要な情報が含まれています。無償で日本語の支援を受けたい場合は、早急に電話あるいは直接窓口にて申込を行ってください。
CHUUKESE	Mei auchea met masowan ei taropwe. Ika pwe ke mochen aninis ren noumw chon chiaku esap kamo, kose mochen kokori kich won tengwa ika fen pusin chuto rech.
MARSHALLESE	Ilo pepa in ewor melele ko aorok. Ne kwoj aikuj jiban na ukok ilo ejjelok wonen, jouj im kokkeitaak kem ilo talboon ak ilo wobij e ien eo emakaaj tata.
KOREAN	이 문서는 중요한 정보가 포함되어 있습니다. 무료로 언어 도움이 필요하시면, 바로 전화 하시거나 오셔서 상담하십시오.
VIETNAMESE	Tài liệu này bao gồm các thông tin quan trọng. Nếu bạn cần hỗ trợ ngôn ngữ miễn phí, xin vui lòng đến gặp trực tiếp chúng tôi hoặc liên lạc qua điện thoại ngay lập tức.