

## EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Labor & Economic Growth  
Workers' Compensation Agency  
PO Box 30016, Lansing, MI 48909

An employer shall report immediately to the agency on Form WC-100 all injuries, including diseases, which arise out of and in the course of the employment, or on which a claim is made and result in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific losses. In case of death, an employer shall also immediately file an additional report on WC-106. See instructions on reverse side for filing/mailling procedures.

### I. EMPLOYEE DATA

|  |   |                                    |                      |             |
|--|---|------------------------------------|----------------------|-------------|
| 1. Social Security Number  | 2. Date of injury   | 3. Employee name (Last, First, MI) |                      |             |
| 4. Address (Number & Street)   |   | 5. City                            | 6. State             | 7. Zip Code |
| 8. Date of birth (MM/DD/YYYY)  | 9. Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female | 10. Number of dependents           | 11. Telephone number |             |
| 12. Tax filing status: <input type="checkbox"/> A. Single <input type="checkbox"/> B. Single, Head of Household <input type="checkbox"/> C. Married, Filing Joint <input type="checkbox"/> D. Married, Filing Separate |   |                                    |                      |             |

### II. EMPLOYER/CARRIER DATA

|   |                           |                       |   |              |
|---|---------------------------|-----------------------|---|--------------|
| 13. Employer name   |                           | 14. Federal ID Number |   |              |
| 15. Injury location code                                  | 16. Mailing location code | 17. UI number         | 18. Type of business (SIC/NAICS)                  |              |
| 19. Employer street address                               |                           | 20. City              | 21. State   | 22. Zip code |
| 23. Insurance company name (if employer not self-insured) |                           |                       | 24. Insurance company telephone number (if known) |              |

### III. INJURY/MEDICAL DATA

|   |  |  |  |                           |
|---|--|--|--|---------------------------|
| 25. Last day worked   | 26. Date employee returned to work (if applicable) |  | 27. Did employee die?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | 28. If yes, date of death |
| 29. Injury city   | 30. Injury state                                   | 31. Injury county  | 32. Did injury occur on employer's premises?<br><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, see item 53)                      |                           |
| 33. Case number from OSHA/MIOSHA log  |  | 34. Time employee began work<br><input type="checkbox"/> a.m. <input type="checkbox"/> p.m.                | 35. Time of event<br><input type="checkbox"/> a.m. <input type="checkbox"/> p.m. If time cannot be determined, check here <input type="checkbox"/> |                           |
| 36. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific.     |  |  |  |                           |
| 37. How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet;" "Worker was sprayed with chlorine when gasket broke during replacement"        |  |  |  |                           |
| 38. Describe the nature of injury or illness  |  |  | 39. Part of body directly affected by the injury or illness  |                           |
| 40. What object or substance directly harmed the employee? Examples: concrete floor, chlorine, radial arm saw. If this question does not apply to the incident, leave it blank. |  |  |  |                           |
| 41. Name of physician or other health care professional   |  | 42. Was employee treated in an emergency room?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Was employee hospitalized overnight as an in-patient?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                              |                           |
| 44. If treatment was given away from the worksite, where was it given? (Include name, address, city, state and zip code of facility)  |  |  |  |                           |

### IV. OCCUPATION AND WAGE DATA

|  |  |   |                                   |  |
|--|--|---|-----------------------------------|--|
| 45. Date hired                         | 46. Total gross weekly wage (highest 39 of 52)   | 47. Number of weeks used  | 48. Value of discontinued fringes |  |
| 49. Occupation (Be specific)           | 50. Was employee a volunteer worker?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 51. Was employee certified as vocationally handicapped?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |
| 52. Date employer notified by employee |  | 53. If temporary service agency, provide name/address of employer where injury occurred.                            |                                   |  |

### V. PREPARER DATA

I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

|  |                          |                      |                   |
|--|--------------------------|----------------------|-------------------|
| <b>Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.</b> |                          |                      |                   |
| 54. Preparer's name (Please print or type)   | 55. Preparer's signature | 56. Telephone number | 57. Date prepared |

**Notice to employee: Questions or errors should be reported immediately to the individual listed above in space 54**