

EMPLOYER DATA

1. Employer's Business Name	2. Federal Employer ID No.
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REPORT FOR MONTH OF: _____ YEAR: _____

INJURY DATA

3 Employee's Name Last First MI			10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected	
15. Social Security Number	16. Sex <input type="checkbox"/> M <input type="checkbox"/> F	17. DOB (m-d-y)	22. Description of Incident				23. Lost Time <input type="checkbox"/> >1 Day - 7 Days <input type="checkbox"/> 8 Days or More	
18. Race/Ethnic Identification <input type="checkbox"/> White (not of Hispanic origin) <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black (not of Hispanic origin) <input type="checkbox"/> American Indian or Alaskan Native							24. Occupational Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	
19. Cause of Injury	20. Location of Injury (see instructions) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C		26. DWC USE ONLY ____ OCC ____ NAT ____ BOD ____ SRCE ____ ACCDT ____ AOS				25. Fatality <input type="checkbox"/> YES <input type="checkbox"/> NO Date (m-d-y)	
21. Employee's Occupation		21a. Hourly Wage						
4 Employee's Name Last First MI			10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected	
15. Social Security Number	16. Sex <input type="checkbox"/> M <input type="checkbox"/> F	17. DOB (m-d-y)	22. Description of Incident				23. Lost Time <input type="checkbox"/> >1 Day - 7 Days <input type="checkbox"/> 8 Days or More	
18. Race/Ethnic Identification <input type="checkbox"/> White (not of Hispanic origin) <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black (not of Hispanic origin) <input type="checkbox"/> American Indian or Alaskan Native							24. Occupational Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	
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21. Employee's Occupation		21a. Hourly Wage						
5 Employee's Name Last First MI			10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected	
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21. Employee's Occupation		21a. Hourly Wage						

date stamp

