

EMPLOYEE INFORMATION

Employee Name (First & Last)		Gender	Hired Date		Hired in NH
ID Type - Employee ID	Date of Birth	Age	Occupation when Injured		
Employee Address	Telephone	Wages per Hour	Hrs per Day	Days per Week	Average Weekly Earnings

INJURY INFORMATION

Injury Date / Time		Date Employer Notified of Injury	Location/Jobsite & Business Name where accident occurred		
Disability Began Date					
Claim Type	Full Wages Paid on Injury Date				
Accident Description					
Body part Injured		Cause of Injury			
Nature of Injury		Witness Name		Witness Phone	
Returned to work?	If so, what date?	If so, at what occupation?	If so, at what duty status?		
Initial Treatment			Initial Treatment Date		
Name of Treating Physician		Name of Treating Hospital		Has injured died? If so, what date	

EMPLOYER INFORMATION

Employer Name		Employer FEIN	Industry Code
Employer Contact Name	Contact Phone Number	Employer Business Address	
Managed Care Organization			
Leased Employee? Client Company		OCIP/Wrap-Up Policy? Name of policy holder	

INSURER INFORMATION

Insurance Carrier	Insurer Type	Policy Number	Telephone Number
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SUBMITTER INFORMATION

Submitter Name	Title of Submitter	Represents	Telephone Number
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THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
SPAULDING BUILDING
95 PLEASANT STREET
CONCORD, NEW HAMPSHIRE 03301

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.

(Name of Injured Employee) SS # _____

(Address of Injured Employee) Daytime Phone # _____

(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)

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 _____ 20

7. Date Disability began _____ 20 _____ 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, NH 03301
WAGE SCHEDULE**

Employee _____ (Name)
 Date of hire _____ Wages per hour _____ Avg. wkly. earnings _____
 Employer _____ (Name)
 Address _____ (No.) _____ (Street) _____ (City - State)

EMPLOYER MUST FORWARD TO INSURANCE CARRIER A COPY OF THIS WAGE SCHEDULE OR A PRINTOUT OF GROSS WAGES NO LATER THAN EMPLOYEE'S FIFTEENTH DAY OF DISABILITY RESULTING FROM INDUSTRIAL ACCIDENT.PER LAB 506.02(b)

THIS WAGE SCHEDULE IS FOR 52 WEEKS PRIOR TO DATE OF INJURY AND MUST BE FILED WITH DEPARTMENT OF LABOR BY INSURANCE CARRIER TOGETHER WITH 9 WCA.

	1	2	3
WEEK ENDING	GROSS WAGES (See Wages Definition)	WEEK ENDING	GROSS WAGES
1		27	
2		28	
3		29	
4		30	
5		31	
6		32	
7		33	
8		34	
9		35	
10		36	
11		37	
12		38	
13		39	
14		40	
15		41	
16		42	
17		43	
18		44	
19		45	
20		46	
21		47	
22		48	
23		49	
24		50	
25		51	
26		52	

CarrierName _____ (Employer's Signature)
 Address _____ (Title)
 Dept. Approval _____ Date _____

GROSS WAGES: In addition to money payments, means reasonable value of board, rent, housing, lodging, fuel or similar advantage received in the course of employment plus gratuities from others, but not including any sum paid by the employer to cover any special expenses entailed by the employee by the nature of his employment. Please provide a brief explanation for weeks with no wages. RSA 281-A:2, Par XV

LAB 500

**THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
CONCORD, NH 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

If Line 1 is below the minimum compensation rate,
multiply Line 6 by 90%. Line 7

Signature – Employee

Signature – Adjuster

Date

Date