LAB 500

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.

_____ 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)

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1 **You are required bylaw (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 maybe 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.

Ken Merrifield
Commissioner of Labor

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:

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

By

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 (11-17)

LAB 500

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.

WEEK ENDING		1 GROSS WAGES (See Wages Definition)		2 WEEK ENDING	3 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

LAB 500

New Hampshire

Employer's First Report of Injury

Submission Date: _____

WEB-8WC –

NHDOL# -

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

SUBMITTER INFORMATION

Submitter Name	Title of Submitter	Represents	Telephone Number

To file this report, email to WorkersComp@dol.nh.gov, Fax Number: (603)271-6149 or
Mail to: NH Department of Labor Workers' Compensation Division 95 Pleasant St. Concord NH 03301

LAB 500

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

Dateof Report _____

Signedby _____

Official Title _____

Tel. No.