LAB 500

# New Hampshire

## Employer's First Report of Injury

**WEB-8WC –**

**Submission Date: _____** **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 firstreport@dol.nh.gov Fax Number: (603)271-0126 or
Mail to: NH Department of Labor Workers' Compensation Division 95 Pleasant St. Concord NH 03301