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**STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION**

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November 30, 2007

TO: INSURANCE CARRIERS, ADJUSTERS AND SELF-INSURED EMPLOYERS

FROM: WORKERS' COMPENSATION RECORDS & CLAIMS BRANCH

SUBJECT: SPECIAL INSTRUCTIONS FOR INSURANCE CARRIERS, ADJUSTERS AND SELF-INSURED EMPLOYERS TO COMPLETE AND FILE INDUSTRIAL ACCIDENT (WC-1), PHYSICIAN (WC-2) AND CARRIER CASE (WC-3) REPORTS UNDER THE HAWAII WORKERS' COMPENSATION LAW

All documents submitted to this office must have claimant's full name, workers' compensation case number (except for new WC-1s), date of accident, etc, under Section 12-10-71. Faxed 2 copies of WC-1s are acceptable provided they are legible, complete, signed and dated with original WC-1 to follow. If not faxing but just mailing original WC-1, please ensure that there are 2 copies. Samples of correctly filled-out WC-1s and WC-3s are attached including a sample on how to report Permanent Total Disability (PTD) and Benefit Adjustment (BA) costs.

You may visit the state Dept. of Labor website at www.hawaii.gov/labor. To locate our forms, click on **Forms** on the left side of screen then scroll down to Workers' Compensation.

WC-1

EMPLOYER'S REPORT OF INDUSTRIAL INJURY (WC-1) must be filed to the Disability Compensation Division (DCD) within 7 working days after the employer has knowledge of the injury which causes absence for one or more days or requiring medical treatment beyond ordinary first aid. All items must be answered accurately to avoid unnecessary delays. Upon receipt of the WC-1s, Records & Claims Section will assign case numbers. We will assign 2007 case numbers, e.g., for all injuries that occurred in 2007 and filed with us by 12/31/07. All WC-1s for 2007 or earlier injuries received on and after 1/01/08, e.g., will be assigned 2008 case numbers. If the accident occurred on Oahu, please send the WC-1 to Honolulu DCD. If the accident occurred on a neighbor island, please submit the WC-1 to the appropriate island District Office of the Department of Labor and Industrial Relations. **Submitted WC-1s either mailed or faxed that are not legible or incomplete missing vital information will be returned.**

NOTE: Please refrain from calling for case numbers until approximately 15 days from date of submission of the WC-1. You may call DCD at (808) 586-9174 if case number listing printout is not received.

WC-2

Only the original **PHYSICIAN'S REPORT (WC-2)** and the original supporting medical documents should be submitted. Do not send duplicates and always submit **final WC-2**. If unable to obtain medical reports, please submit to us copy of your request letter to the attending physician to show proof of compliance. You may submit photocopies if original medical reports could not be obtained. As for other medical reports such as narratives, if a claim is denied, they should be submitted immediately. For non-controverted medical only cases, first & final WC-2s only are required to be submitted. Final WC-2 should

be attached to the final WC-3 if not submitted earlier. If there is TTD, WC-2s indicating TTD dates should also be submitted. When cases are ready for hearing, we need all medical reports at least 10 days before the hearing. When a cover letter states that there are documents attached, please ensure that they are really attached before sending to DCD.

WC-3

CARRIER'S CASE REPORT (WC-3) - A final WC-3 must be filed within 30 days after final payment has been made. All open cases with or without current year costs must have year-end reports by January 31 of the following year. If you can't meet the deadline for submission, you may request for extension from DCD Administrator Gary Hamada at (808) 586-9151. Multiple case numbers listed on Compromises and Stipulations must be open to process these documents. Every case must have a final WC-3 to formally close the case after the awards have been paid. For "washout" Compromises, indicate in carrier's comments of each WC-3 which case number has received the lump sum payments. Reopened cases must have a final WC-3 to re-close even though further liability may have been denied. Defense costs such as employer's attorney fees, subpoenas of records, penalty assessment and independent medical examinations/PPD ratings **must not be reported on the WC-3.** These defense costs are absorbed by the carrier. Do not enter refund payment data in any of the columns but should be indicated in the Carrier's Comments section. LIST TTD AND TPD DATES, AND MEDICAL DEDUCTIBLE INFORMATION ALSO IN THE CARRIER'S COMMENTS SECTION. **TAKE NOTE: PRIOR YEARS AND CUMULATIVE YEAR-TO-DATE TOTALS ARE TO BE REPORTED IN THE PROPER COLUMNS each time a WC-3 year end report or a final WC-3 report is generated for same case.** Lastly, please ensure that original and copy of WC-3s submitted to DCD are stapled together.

Again, please ensure that the information provided on the WC-1s, WC-2s and WC-3s are clear, legible, complete and accurate. WC-1 and WC-3 reports will be returned to the insurance carrier/adjuster/self-insured employer due to errors or incomplete data that will prevent the reports from being entered into our computer system. Minimum acceptable pitch of printed reports is **12** characters per inch.

Pursuant to Section 386-95, HRS, employers who fail to submit timely reports are subject to fines of up to \$5,000. NOTE: All our letters and telephone inquiries will be made to your local office and not to a mainland office. We are also now capable of e-mail communication with the industry. Should you have questions, please call (808) 586-9174.

We also request your assistance in assuring that all documents for neighbor island cases including subpoena requests be submitted to the respective island District Office and **NOT** to the Honolulu address. **Case numbers that start with 1 belongs to Hilo; 2 - Oahu; 4 - Kauai; 5,7,8 - Maui; and 9 - Kona/West Hawaii. Transferred cases if known are the exceptions.**

ISLAND/DISTRICT OFFICE	MAILING ADDRESS	PHONE NUMBER
Oahu	P O Box 3769, Honolulu, HI 96813	808-586-9161
Hilo	75 Aupuni St, Hilo, HI 96720	808-974-6464
Kona/West Hawaii	P O Box 49, Kealahou, HI 96750	808-322-4808
Maui	2264 Aupuni St, Wailuku, HI 96793	808-984-2072
Kauai	3060 Eiwa St #202, Lihue, HI 96766	808-274-3351

COMPLETING THE WC-1

NOTE: The shaded blocks are for DCD use only.

A. IDENTIFICATION SECTION

1. **NAME OF EMPLOYEE** - Enter last name first, then first name, then middle initial. Please indicate legal names and not nicknames. Jr, Sr, III or IV, etc. should be placed **after the first name** in the same box for DCD computer input requirements.

2. SOCIAL SECURITY NUMBER - Self-explanatory. Please do not input dashes in between numbers or "0s" in the block if not known. If SSN is not provided, WC-1 will be returned.
 3. DATE OF BIRTH. Self-explanatory. Date should have 6 digits, e.g., 11/30/07.
 4. SEX AND MARITAL STATUS - Place an "X" in the applicable boxes.
 5. ADDRESS AND PHONE NUMBER - Use the mailing address. Notify DCD in writing of changes in mailing address as soon as practicable. Input area code when listing phone number.
 6. OCCUPATION - Enter job title.
 7. DATE HIRED - Self-explanatory. Date should have 6 digits, e.g., 11/30/07.
 8. DEPARTMENT - Enter name of department to which employee was assigned at the time of injury or illness. In the absence of formal department titles, enter a brief description of the normal work place to which employee was assigned.
 9. PAYROLL COMPENSATION CLASS CODE - Enter employee's rating manual occupation class code. This information is for the Hawaii Insurance Rating Bureau to assure proper rating and premium determination.
 10. REGISTERED EMPLOYER - Enter name exactly as it appears on the workers' compensation insurance policy or certificate of self-insurance. DBAs should only be entered in the "DBA" block.
 11. ADDRESS AND PHONE NUMBER - Employer's address and phone number. Input area code when listing phone number.
 12. NATURE OF BUSINESS - Enter principal type of business activity engaged in, e.g., restaurant, service station, contracting, auto repair shop, government, etc.
 13. DATE INJURY/ILLNESS REPORTED - Enter date employer (management personnel) was informed of the injury or illness. This date **cannot** precede Date of Injury. Dates should have 6 digits, e.g., 11/30/07. WC-1 will be returned if date is transposed with Date of Injury.
 14. DATE OF INJURY/ILLNESS - Self-explanatory. If exact date is not known, enter an approximate date. Date should have 6 digits, e.g., 11/30/07.
 15. DOL NUMBER - Enter the 10-digit Department of Labor (DOL) account number (same as Unemployment Insurance {UI} or Temporary Disability Insurance {TDI} account number). This is a mandatory box and should always be completed. Do not put dashes or spaces in between numbers. **Correct example:** 0000123456.
- B. DETAIL OF INJURY/ILLNESS
1. TIME OF INJURY/ILLNESS - Enter a.m. or p.m. time of injury.
 2. PLACE OF INJURY/ILLNESS IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS - Address or brief description of location, e.g. employer's address is in Oahu but employee was hurt on Maui; therefore put Maui as place of injury.
 3. ON EMPLOYER'S PREMISES - Enter "X" in the appropriate box.
 4. HOW DID THIS ACCIDENT OCCUR?/TIME WORKSHIFT BEGAN - Describe fully the events that resulted in injury or occupational disease. Use separate sheet if necessary as an attachment. Put time with a.m. or p.m. on Time Work shift Began.
 5. WHAT WAS EMPLOYEE DOING WHEN INJURED? - Be specific. Identify also the tools, equipment or material the employee was using at time of injury.
 6. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE - For example: the machine employee struck against or tool that struck him; the vapor or poison inhaled or swallowed, the chemical that irritated the skin, etc. In cases of strains, the object he was lifting, pulling, etc.
 7. DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED - Mandatory field. Describe the injury fully and clearly designating the affected part of the body, e.g., amputation of right arm or left arm, crushing injury to chest, lead poisoning, dermatitis of right arm and hand, back strain, strain to left side of the neck, crushed left toe, laceration on right index finger, sprained left foot or right foot, left eye irritation, blindness to both eyes, etc. WC-1 will be returned if part of the body is missing.
- C. TIME LOST INFORMATION
1. DATE DISABILITY BEGAN - If an employee is unable to complete the regular work shift because of a work injury, the employee shall be deemed totally disabled for that day. If

the employee worked the scheduled hours on the day of the accident, enter the first day the employee was unable to work. Date should have 6 digits, e.g., 11/30/07.

2. WAS EMPLOYEE FURNISHED MEALS OR LODGING? - Enter "X" in the appropriate box.
3. AVERAGE WEEKLY WAGE (AWW) - The AWW must be computed in a manner that represents the employee's AWW from all employment covered by law at the time of the injury. Computation instructions follow:
 - 1) If an employee works on a straight regular 40-hour workweek (no overtime or additional earnings) and:
 - a) is employed only at an hourly rate, multiply the hourly rate by 40;
 - b) is only on a predetermined and fixed semi-monthly salary, multiply the semi-monthly salary by 24 periods then divide by 52 weeks;
 - c) is only on a predetermined and fixed monthly salary, multiply the monthly salary by 12 months then divide by 52 weeks.
 - 2) Computation of average weekly wages: Provided that where the employee holds part-time employment of fewer than 35 hours per week, the employee's AWW shall be the hourly rate at the place of employment where the injury occurred multiplied by the average hours worked in the 52 weeks or portions thereof preceding the week in which the injury occurred, for the calculation of temporary partial disability and temporary total disability benefits only. (Section 386-51, HRS)
 - 3) If an employee is employed by more than one employer, the employer in whose employment the injury occurred must obtain the injured employee's earnings from the other employment completing a WC-14 form from DCD entitled "Employee's Wage Report for Fifty-Two Weeks Prior to Date of Injury." This form must be mailed back to DCD upon completion.
 - 4) If an employee has had overtime earnings and/or bonuses which caused fluctuations in earnings, obtain the total earnings for the 12 months preceding the injury and divide by 52 weeks. If, however, because of sickness or other personal circumstances the employee did not work all of the 52 weeks, then use the number of weeks actually worked as the divisor instead of 52.
 - 5) If an employee at the time of the injury was employed at a higher rate of pay than anytime during the 12 months preceding the injury, determine average weekly earnings solely on the higher rate of pay.

When an employee at the time of the injury was employed at higher wages than any other period in the preceding 12 months and had earned overtime pay during the 12-month period, the AWW is computed by adding the average weekly overtime earnings to the average weekly straight time pay. The average weekly overtime earnings is obtained by (a) dividing the total overtime hours worked during the 12-month period by 52, and (b) multiplying it by the overtime hourly rate based on the higher wages. The average weekly straight time pay is obtained by multiplying the straight time hourly rate based on the higher wages by the total number of straight time hours normally worked in a week.

- 6) If an employee is under 25 years of age and sustains an injury causing permanent disability or death, the AWW shall be computed on the basis of the wages the employee would have earned had the employee been 25 years of age.

- a) If the employee is employed as an apprentice or trainee under the terms of an apprenticeship or on-the-job training program, AWW shall be calculated on the basis of the rate of pay the employee would receive at age 25 under the apprenticeship or trainee agreement, plan, or contract. An apprenticeship or on-the-job training program is one which is registered with the Department of Labor and Industrial Relations, expressed in writing in a collective bargaining agreement or an employment contract, or one which the Director determines bears substantial similarities to that of on-the-job or career training program based on a mutual employer-employee understanding.
- b) If the employee is not an apprentice or trainee, the AWW shall be the median pay of the lowest and highest paid 25-year old employees in a similar occupation by the employer.

If there are no 25-year old employees in a similar occupation with the same employer, obtain the median pay from 25-year olds in a similar occupation in employment with another employer in this State.

4. IF EMPLOYEE IS BACK TO WORK GIVE DATE - Self-explanatory. If there is no lost time, enter date of injury. Date should have 6 digits, e.g., 11/30/07.
 5. WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY ILLNESS? - Enter "X" in the applicable box.
 6. IF EMPLOYEE DIED GIVE DATE - Self-explanatory. Date should have 6 digits, e.g., 11/30/07.
 7. GIVE NAMES AND ADDRESSES OF SURVIVORS ON BACK - Names and mailing addresses of surviving spouse, minor dependent children, and/or other survivors should be listed on the back of the form. Attach marriage and death certificates if obtainable from dependents.
 8. HOURLY WAGE - Enter employee's hourly wage in whole numbers. Enter the whole numbers to the left of the median line, and cents to the right. This is a critical mandatory field. Enter this information even if no time loss at time of injury for there could be time loss in future if claimant's condition worsens, or if there's surgery, etc. This will help DCD avoid time-consuming phone calls, letters or e-mails for needed wage information resulting in more expeditious processing of the case.
 9. MONTHLY SALARY - If the employee is paid fixed monthly salary, enter the amount of the monthly salary.
 10. HOURS WORKED PER WEEK - Include overtime hours, if any. This is a critical mandatory field that should be immediately provided to avoid time-consuming phone calls, letters or e-mails from DCD. Absence of necessary data delays the processing of the case.
- D. TREATMENT
1. NAME OF PHYSICIAN/ADDRESS - Self-explanatory.
 2. NAME OF MEDICAL FACILITY/ADDRESS - Self-explanatory.
 3. INPATIENT OVERNIGHT? EMERGENCY ROOM ONLY? - Enter "X" in the appropriate box.
- E. INSURANCE
1. CARRIER ID - Self-explanatory. This information is mandatory.
 2. NAME OF WC INSURANCE CARRIER - Enter the name as it appears on the insurance policy; if employer is self-insured, enter "Self-Insured."
 3. NAME OF ADJUSTING COMPANY - Third party administrator. If a general agent handles or administers the workers' compensation affairs for the insurance carrier, enter the full name of the agency.
 4. IS LIABILITY DENIED - WHY? - Briefly state reason for denial.
 5. IS LIABILITY DENIED? Enter "X" in the chosen box. **If both boxes are blank, claim will be processed as LIABILITY ACCEPTED.**
 6. POLICY NUMBER - Self-explanatory.

7. POLICY PERIOD - Self-explanatory. The date of the injury should be within the policy period.
 8. ADJUSTER NAME - Name of the person that adjusts the case.
 9. CARRIER CASE NUMBER - Enter the carrier case number if you wish the number to appear on the case number listing printout that we regularly mail to you.
 10. ADJUSTER ID - Self-explanatory. This information is necessary to avoid delays in claim processing.
 11. MEDICAL DEDUCTIBLE - Self-explanatory. If no deductible, leave blank. Don't put "0s."
- F. SIGNATURE
1. SIGNATURE - Provide employer authorized signature (**NOT** the Claimant's) on the signature box. **If not signed, WC-1 will be returned.**
 2. TITLE - Title of authorized signatory.
 3. DATE - Enter date WC-1 was signed. Use 6 digits, e.g., 11/30/07.

WC-1s submitted to DCD should be typewritten or printed in black ink. They should be legible with accurate and complete information. Please ensure that documents are stapled together for each individual claimant. Remember to furnish claimant copy. It is DCD's recommendation that carriers/adjusters regularly train the employers on how to correctly fill out the WC-1s and to inform them **NOT TO SEND DIRECTLY TO DCD** but should be sent to their adjuster.

COMPLETING THE WC-3

1. DCD CASE NUMBER - Enter the 8-digit case number. Do not leave blank. Refer to the case number listing printout for case number. If not received after 15 days, you may call DCD at (808) 586-9174. Do not enter alpha comments in this box; do not put hyphens or spaces in between numbers. Ensure that the number is correct and that it does not belong to another claimant (which we have seen a lot of).
2. CARRIER CASE NUMBER - Enter the carrier or self-insured case or file number.
3. CARRIER ID - This is a mandatory field. Do not leave blank.
4. CLAIMANT'S NAME AND ADDRESS - Enter the claimant's name and address as they appear on the WC-1. If claimant's mailing address has changed, the current address should be shown.
5. SOCIAL SECURITY NUMBER - Self-explanatory. Ensure accuracy to prevent transposition of numbers. We occasionally receive two different SSN numbers (with a difference of 2 numbers only) for same claimant, hence the need to check.
6. DATE OF INJURY/ILLNESS - Ensure that date is the same as on the WC-1. Date should have 6 digits, e.g., 11/30/07.
7. EMPLOYER - Enter employer's name as shown on the WC-1.
8. CARRIER, ADJUSTER ADDRESS - Enter name of carrier or self-insured employer exactly as shown on the WC-1. If claim is being handled by an insurance agency or an independent adjuster, the agency or adjuster's name and address should appear under the name of carrier.
9. INDIVIDUAL TO CONTACT - Enter the name of the carrier, agent, adjuster or self-insured employer representative to whom inquiries regarding the WC-3, payment and/or other claims information maybe directed.
10. TELEPHONE NUMBER - Enter the phone number of the representative to be contacted.
11. TYPE OF REPORT - Enter "X" in the applicable box. **Cannot "X" more than one box for each WC-3 submission.**
 - 1) DATE OF FIRST INCOME REPLACEMENT PAYMENT - Enter "X" in the box and enter date first TTD payment was made. **DO NOT REPORT AMOUNTS IN THE TTD PAYMENT COLUMN.**
 - 2) REOPEN CASE - Enter "X" in this box for cases being reopened due to recurring symptoms, resumption of medical care, settlement, etc. Please indicate under the Carrier's Comment Section if reopening is accepted or denied.

- 3) HEARING REQUESTED - Do not use this box anymore to request hearings. Use instead our WC-77 Request for Hearing form.
- 4) NO LOST TIME/MEDICAL ONLY - Do not use this box anymore. **Use box #7 for all closures.**
- 5) FINAL PAYMENT TO PREVIOUSLY ENDED CASE - Enter "X" in this box if additional payment or adjustment is being made to correct a previous payment. Enter the additional payment in "Payments Not Previously Reported" column. Enter previous payment in "Prior Payments" column, add the 2 columns, then enter the total amount in "Total Payments Made to Date" column. Do not put year anymore.
- 6) YEAR END REPORT - **This is a mandatory report for all open cases up to and including 12/31 of each year to be submitted to DCD no later than 1/31 of the following year even if no payments were made yet.** An open case is one that has not been closed by the submission of a final report. Enter "X" in the box and enter year, e.g., 2007, then enter payment in "Payments Not Previously Reported" column. If no payments made, leave the first column blank.
- 7) FINAL REPORT - This report must be submitted within 30 days after final payment of all applicable benefits. Please do not wait for the end of the year to submit final report. Do not inundate DCD with both year end and final reports at the end of the year - just year end reports. Enter "X" in box, enter payment year/closing year, e.g., 2007. Enter current payment in "Payments Not Previously Reported" column. If no current or additional payments but just closing, the previous payments must be entered in the "Prior Payments" column then carried over to the "Total Payments Made to Date" column.
12. RETURN TO WORK DATE - Self-explanatory. If there are multiple return-to-work dates, enter only the most recent date. Date should be 6 digits, e.g., 11/30/07.
13. WEEKLY COMP RATE - TTD comp rate. If there's TPD comp rate, please enter next to the TTD comp rate separated by space or semi-column and properly indicated.
14. BENEFIT PAYMENTS - Numeric payment amounts. Omit commas, dollar signs, hyphens, and "0s" for no payment. Amounts must be placed within the blocks. If no payments, leave the blocks blank.
 - 1) PAYMENTS NOT PREVIOUSLY REPORTED (CURRENT YEAR AMOUNTS) - Enter only payments **not previously reported** to DCD. Payments made in prior years and not previously reported should be included in this column with comments in the Carrier's Comments Section especially if it's TTD or TPD payment. Enter only whole days in the "Days" column, no fractions.
 - 2) PRIOR PAYMENTS - Enter only total payments **previously reported**.
 - 3) TOTAL PAYMENTS MADE TO DATE - Sum total of the first 2 columns.
15. CARRIER'S COMMENTS - Use to indicate TTD & TPD dates. Do not provide continuous date periods if there are breaks in-between but list the **actual** dates to aid us in our calculations. Use this section also for benefit adjustment reimbursement requests, to provide explanations and to communicate with DCD, e.g., claimant was discharged from further medical care, paying advance PPD benefits, no time loss, records only claim (for no cost claims), reopening - accepting or denying, etc.
16. MEDICAL DEDUCTIBLE - Self-explanatory. If none, leave blank.
17. SIGNATURE, POSITION & DATE - Self-explanatory. Signature & date are mandatory fields. If not provided, WC-3 will be returned.

Additional DOs and DONTs:

- Ensure that medical reports are submitted to DCD to support WC-3s with medical cost payments. This will eliminate the time-consuming phone calls, letters or e-mails from DCD to the adjusters who fail to submit.
- Be careful with the TTD calculations to avoid underpayments. Ensure that proper WCR is used. Correct reporting will help DCD process cases more expeditiously and aid in the timely closure of files. Be careful with the 3-day waiting period.

- Close files that are ready instead of submitting yearly year end reports, e.g., submitting year end reports for 5 consecutive years when there's no current treatment, no current payments, no activity, etc.
- If there are Decisions & Orders, Stipulations, Compromises, ensure that payments on WC-3s are in accordance with the award amounts. This will eliminate the time-consuming phone inquiries, letters or e-mails from DCD.
- Do not add benefit adjustment (BA) payments to PTD amounts and input in the PTD column. BA should be separate from PTD payments and should be reflected in the Carrier's Comments Section.
- Do not submit, e.g., a year end report 2007 for a 2008 case even if the injury occurred in 2007 (case was assigned 2008 case number, e.g., due to late reporting to DCD missing the 12/31/07 deadline). Be cognizant of the date you mailed WC-1s to DCD. Allow several days of mail transit. If mailed to us on 12/30 or 12/31, for instance, the WC-1s will surely be assigned the following year's case numbers.
- Respond promptly to DCD inquiries to be in compliance.
- Incomplete or incorrect WC-1s and WC-3s will be returned.

If you have any questions relating to these instructions, please feel free to call Angeles Ildfonso of the Records & Claims Section at (808) 587-8769 or e-mail her at Angeles.E.Ildfonso@hawaii.gov. We welcome suggestions to make our instructions clearer. We appreciate your efforts to ensure that filings are made accurately and timely.

Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a \$5,000 fine. (Sec. 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured employee a copy of this report.

SAMPLE

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

CASE NUMBER

IDENTIFICATION SECTION

NOTE: DO NOT WRITE IN SHADED BLOCKS

EMPLOYEE NAME - LAST DOE	FIRST JANE	M.I. E	SOC SEC NO 575226645	DATE OF BIRTH 03 / 20 / 56 MM / DD / YY	SEX <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE	MARITAL STATUS MARRIED <input type="checkbox"/> SINGLE <input checked="" type="checkbox"/>	DATE RECEIVED MM / DD / YY
ADDRESS 91-234 Sample Street #304D		ADDITIONAL ADDRESS INFORMATION (C/D)		CITY Honolulu	STATE HI	ZIP CODE 96813	
PHONE (808) 123-4567	OCCUPATION Teacher	DATE HIRED 10 / 08 / 04 MM / DD / YY	YRS EMP'D CODE	DEPARTMENT Dept of Education	PAYROLL COMP CLASS CODE	OCC. CODE	

REGISTERED EMPLOYER UKULELE ELEMENTARY SCHOOL	DBA		
ADDRESS 1832 Bonn Street	CITY Honolulu	STATE HI	ZIP CODE 96813

PHONE (808) 890-1112	NATURE OF BUSINESS State Govt/Education	DATE INJURY/ILLNESS REPORTED 02 / 12 / 05 MM / DD / YY	DATE OF INJURY/ILLNESS 02 / 12 / 05 MM / DD / YY	PREFAB <input type="checkbox"/> WC-2 <input type="checkbox"/> WC-5	DOL NUMBER S000008765	DBA
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DETAIL OF INJURY / ILLNESS

TIME OF INJURY/ILLNESS 8:30 AM / PM	TIME OF I/I CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS	CITY	STATE	ON EMPLOYER'S PREMISES <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	INDUSTRIAL CODE
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HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary)

Tripped on big rock by the school playground near the Administration Office. Tried to save self from falling by putting her right hand on the ground. As she fell down, her body twisted to the right and she fell on her right arm.

7:45 AM / PM

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using)

Walking towards the playground to get the 4th graders back inside the classroom.

TASK	ACTIVITY	ACCIDENT FACTOR
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OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin. In cases of strains, the thing he was lifting, pulling, etc.)

The rock that tripped Ms. Doe. She did not see it as she was concentrating on getting the students' attention.

DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED Fractured right arm.	YES NO	NATURE OF INJURY	PART OF BODY
DISFIGUREMENT	<input type="checkbox"/> <input type="checkbox"/>		
BURNS	<input type="checkbox"/> <input type="checkbox"/>		

TIME LOST INFORMATION

DATE DISABILITY BEGAN 02 / 12 / 05 MM / DD / YY	WAS EMPLOYEE FURNISHED MEALS OR LODGING? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	AVG WKLY WAGE 675 100	IF EMPLOYEE IS BACK TO WORK GIVE DATE 02 / 19 / 05 MM / DD / YY	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	IF EMPLOYEE DIED GIVE DATE MM / DD / YY	HOURLY WAGE 16 188	MONTHLY SALARY 2925 00	HRS WKED / WK 40 1	WEIGHING FACTOR
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TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN David Smith, M.D.	ADDRESS 122 Lusitana St, Hon, HI 96814	PHYSICIAN I.D. CODE
NAME OF MEDICAL FACILITY Queen's Hospital	ADDRESS 122 Lusitana St, Hon, HI 96814	INPATIENT OVERNIGHT? EMERGENCY ROOM ONLY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

CARRIER I.D. 1999	NAME OF WC INSURANCE CARRIER Self-Insured	NAME OF ADJUSTING COMPANY DHRD	IF LIABILITY DENIED - WHY?	IS LIABILITY DENIED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
POLICY NO. S000000050	POLICY PERIOD 01/01/45 - present	ADJUSTER NAME ANNE COURAGEOUS	CARRIER CASE NO.	

SIGNATURE LEILANI SMART	TITLE Vice-Principal	DATE 02 / 12 / 05 MM / DD / YY
----------------------------	-------------------------	--------------------------------------

WC-3 CARRIER'S CASE REPORT

Case No. 20512345
FOR OFFICE USE ONLY Date Received Mo. / Day / Yr. Carrier Case No. 445566 Carrier I.D. 1999

CLAIMANT NAME AND ADDRESS

JANE DOE
91-234 Sample Street #304D
Honolulu, HI 96813

SAMPLE OF BOX #1

SOC. SEC. NO. 575226645

DATE OF INJURY/ILLNESS 02/12/05

EMPLOYER DEPT OF EDUCATION

CARRIER Self-Insured

ADJUSTER DHRD

ADDRESS 123 Beretania Street #111

INDIVIDUAL TO CONTACT Tom Hawkins

TELEPHONE NO. (808) 234-6656

CHECK ONE:

- DATE OF FIRST INCOME REPLACEMENT PAYMENT: 03 / 12 / 05
MO. / DAY / YR.
- REOPEN CASE
- HEARING REQUESTED
- NO LOST TIME/MEDICAL ONLY - PAYMENT DATE MO. / DAY / YR.
- FINAL PAYMENT TO PREVIOUSLY ENDED CASE
- YEAR END REPORT FOR
- FINAL REPORT (COPY TO EMPLOYEE) FOR

NOTE: WHEN 4, 5, 6 & 7 ARE CHECKED, PAYMENT BLOCK MUST BE FILLED IN.

RETURN TO WORK DATE: MO. / DAY / YR.

WEEKLY COMP. RATE

BENEFIT PAYMENTS	Days	Payments Not Previously Reported	Prior Payments	Total Payments Made to Date
1. Temporary Total *		\$	\$	\$
2. Temporary Partial *		\$	\$	\$
3. Permanent Total		\$	\$	\$
4. Permanent Partial		\$	\$	\$
5. Death		\$	\$	\$
6. Disfigurement		\$	\$	\$
7. Medical/Other Costs		\$	\$	\$
8. Services of Attendant		\$	\$	\$
9. Rehabilitation		\$	\$	\$

Carrier's Comments: _____

Medical Deductible: _____

*List Date(s) of Disability in Carrier's Comments Section.

I hereby certify the accuracy of all of the above statements.

NOTICE TO EMPLOYEE: With the final payment of compensation (as indicated hereon) on your industrial injury of / / ,
month day year

SIGNATURE Tom Hawkins

identified as Case No. , the case shall be closed. This determination shall not constitute a bar to your reopening rights as provided by Section 386-89, HRS, nor to future medical benefits

POSITION Claims Mgmt Specialist

DATE 03/14/05

WC-3 CARRIER'S CASE REPORT

CLAIMANT NAME AND ADDRESS

JANE DOE
91-234 Sample Street #304D
Honolulu, HI 96813

SAMPLE OF BOX #5

Case No. 20512345
FOR OFFICE USE ONLY Date Received Mo. / Day / Yr.
Carrier Case No. 445566
Carrier I.D. 1999

SOC. SEC. NO. 575226645

DATE OF INJURY/ILLNESS 02/12/05

EMPLOYER DEPT OF EDUCATION

CARRIER Self-Insured

ADJUSTER DHRD

ADDRESS 123 Beretania Street #111

INDIVIDUAL TO CONTACT Tom Hawkins

TELEPHONE NO. (808) 234-6656

CHECK ONE:

- DATE OF FIRST INCOME REPLACEMENT PAYMENT: MO. / DAY / YR.
- REOPEN CASE
- HEARING REQUESTED
- NO LOST TIME/MEDICAL ONLY - PAYMENT DATE MO. / DAY / YR.
- FINAL PAYMENT TO PREVIOUSLY ENDED CASE FOR
- YEAR END REPORT FOR _____
- FINAL REPORT (COPY TO EMPLOYEE) FOR _____

NOTE: WHEN 4, 5, 6 & 7 ARE CHECKED, PAYMENT BLOCK MUST BE FILLED IN.

RETURN TO WORK DATE: MO. / DAY / YR.

WEEKLY COMP. RATE 450.00

BENEFIT PAYMENTS	Days	Payments Not Previously Reported	Prior Payments	Total Payments Made to Date
1. Temporary Total *		\$	\$ 257.14	\$ 257.14
2. Temporary Partial *		\$	\$	\$
3. Permanent Total		\$	\$	\$
4. Permanent Partial		\$	\$	\$
5. Death		\$	\$	\$
6. Disfigurement		\$	\$	\$
7. Medical/Other Costs		\$ 150.00	\$ 150.00	\$ 300.00
8. Services of Attendant		\$	\$	\$
9. Rehabilitation		\$	\$	\$

Carrier's Comments: _____

Medical Deductible: _____

*List Date(s) of Disability in Carrier's Comments Section.

I hereby certify the accuracy of all of the above statements.

NOTICE TO EMPLOYEE: With the final payment of compensation (as indicated hereon) on your industrial injury of month day year

SIGNATURE Tom Hawkins

identified as Case No. _____, the case shall be closed. This determination shall not constitute a bar to your reopening rights as provided by Section 386-89, HRS, nor to future

POSITION Claims Mgmt Specialist

DATE 04/30/06

WC-3 CARRIER'S CASE REPORT

CLAIMANT NAME AND ADDRESS

JANE DOE
91-234 Sample Street #304D
Honolulu, HI 96813

SAMPLE OF BOX #6

Case No. 20512345		
FOR OFFICE USE ONLY Date Received		
Mo.	Day	Yr.
Carrier Case No. 445566		
Carrier I.D. 1999		

SOC. SEC. NO. 575226645
DATE OF INJURY/ILLNESS 02/12/05
EMPLOYER DEPT OF EDUCATION
CARRIER Self-Insured
ADJUSTER DHRD
ADDRESS 123 Beretania Street #111
INDIVIDUAL TO CONTACT Tom Hawkins
TELEPHONE NO. (808) 234-6656

CHECK ONE:

- DATE OF FIRST INCOME REPLACEMENT PAYMENT: MO. / DAY / YR.
- REOPEN CASE
- HEARING REQUESTED
- NO LOST TIME/MEDICAL ONLY - PAYMENT DATE MO. / DAY / YR.
- FINAL PAYMENT TO PREVIOUSLY ENDED CASE
- YEAR END REPORT FOR 2007
- FINAL REPORT (COPY TO EMPLOYEE) FOR _____

NOTE: WHEN 4, 5, 6 & 7 ARE CHECKED, PAYMENT BLOCK MUST BE FILLED IN.

RETURN TO WORK DATE: MO. / DAY / YR.

WEEKLY COMP. RATE 450.00

BENEFIT PAYMENTS	Days	Payments Not Previously Reported	Prior Payments	Total Payments Made to Date
1. Temporary Total *		\$	\$ 257.14	\$ 257.14
2. Temporary Partial *		\$	\$	\$
3. Permanent Total		\$	\$	\$
4. Permanent Partial		\$	\$	\$
5. Death		\$	\$	\$
6. Disfigurement		\$	\$	\$
7. Medical/Other Costs		\$ 200.00	\$ 300.00	\$ 500.00
8. Services of Attendant		\$	\$	\$
9. Rehabilitation		\$	\$	\$

Carrier's Comments: _____

Medical Deductible: _____

*List Date(s) of Disability in Carrier's Comments Section.

I hereby certify the accuracy of all of the above statements.

NOTICE TO EMPLOYEE: With the final payment of compensation (as indicated hereon) on your industrial injury of month / day / year, identified as Case No. _____, the case shall be closed. This determination shall not constitute a bar to your reopening rights as provided by Section 386-89, HRS, nor to future medical benefits.

SIGNATURE Tom Hawkins

POSITION Claims Mgmt Specialist

DATE 01/15/08

WC-3 CARRIER'S CASE REPORT

CLAIMANT NAME AND ADDRESS

JANE DOE
91-234 Sample Street #304D
Honolulu, HI 96813

SAMPLE OF BOX #7

Case No. 20512345		
FOR OFFICE USE ONLY		
Date Received		
Mo.	Day	Yr.
Carrier Case No. 445566		
Carrier I.D. 1999		

SOC. SEC. NO. 575226645

DATE OF INJURY/ILLNESS 02/12/05

EMPLOYER DEPT OF EDUCATION

CARRIER Self-Insured

ADJUSTER DHRD

ADDRESS 123 Beretania Street #111

INDIVIDUAL TO CONTACT Tom Hawkins

TELEPHONE NO. (808) 234-6656

CHECK ONE:

- DATE OF FIRST INCOME REPLACEMENT PAYMENT: MO. / DAY / YR.
- REOPEN CASE
- HEARING REQUESTED
- NO LOST TIME/MEDICAL ONLY - PAYMENT DATE MO. / DAY / YR.
- FINAL PAYMENT TO PREVIOUSLY ENDED CASE
- YEAR END REPORT FOR _____
- FINAL REPORT (COPY TO EMPLOYEE) FOR 2008

NOTE: WHEN 4, 5, 6 & 7 ARE CHECKED, PAYMENT BLOCK MUST BE FILLED IN.

RETURN TO WORK DATE: MO. / DAY / YR.

WEEKLY COMP. RATE 450.00

BENEFIT PAYMENTS	Days	Payments Not Previously Reported	Prior Payments	Total Payments Made to Date
1. Temporary Total *		\$	\$ 257.14	\$ 257.14
2. Temporary Partial *		\$	\$	\$
3. Permanent Total		\$	\$	\$
4. Permanent Partial		\$ 5000.00	\$	\$ 5000.00
5. Death		\$	\$	\$
6. Disfigurement		\$	\$	\$
7. Medical/Other Costs		\$ 100.00	\$ 500.00	\$ 600.00
8. Services of Attendant		\$	\$	\$
9. Rehabilitation		\$	\$	\$

Carrier's Comments: _____

Medical Deductible: _____

*List Date(s) of Disability in Carrier's Comments Section.

I hereby certify the accuracy of all of the above statements.

NOTICE TO EMPLOYEE: With the final payment of compensation (as indicated hereon) on your industrial injury of / / , month day year

SIGNATURE Tom Hawkins

identified as Case No. _____, the case shall be closed. This determination shall not constitute a bar to your reopening rights as provided by Section 386-89, HRS, nor to future

POSITION Claims Mgmt Specialist

DATE 05/30/08

WC-3 CARRIER'S CASE REPORT

Case No. 27902929		
FOR OFFICE USE ONLY Date Received		
Mo.	Day	Yr.
Carrier Case No. HWC 1979		
Carrier I.D. 1800		

CLAIMANT NAME AND ADDRESS

JACK RUNNER
313 Sunset Avenue
Makaha, Hawaii 69777

PTD - BENEFIT ADJUSTMENT

SAMPLE

CHECK ONE:

- DATE OF FIRST INCOME REPLACEMENT PAYMENT: MO. / DAY / YR.
- REOPEN CASE
- HEARING REQUESTED
- NO LOST TIME/MEDICAL ONLY - PAYMENT DATE MO. / DAY / YR.
- FINAL PAYMENT TO PREVIOUSLY ENDED CASE FOR 19
- YEAR END REPORT FOR 192001
- FINAL REPORT (COPY TO EMPLOYEE) FOR 19

NOTE: WHEN 4, 5, 6 & 7 ARE CHECKED, PAYMENT BLOCK MUST BE FILLED IN.

RETURN TO WORK DATE: MO. / DAY / YR.

\$258.00 Ben Adj
\$179.00 Regular

WEEKLY COMP. RATE

OC. SEC. NO. 909-34-1779
DATE OF INJURY/ILLNESS 1/3/79
EMPLOYER BIG MAC RESTAURANT
CARRIER BIG INSURANCE COMPANY
ADJUSTER BIG INSURANCE COMPANY
ADDRESS 1299 So. King St, Hon 96813
INDIVIDUAL TO CONTACT Jane Monday
TELEPHONE NO. 222-9999

BENEFIT PAYMENTS	Days	Payments Not Previously Reported	Prior Payments	Total Payments Made to Date
1. Temporary Total *		\$	\$	\$
2. Temporary Partial *		\$	\$	\$
3. Permanent Total	365	\$ 9359.14	\$ 84053.27	\$ 93412.41
4. Permanent Partial		\$	\$	\$
5. Death		\$	\$	\$
6. Disfigurement		\$	\$	\$
7. Medical/Other Costs		\$ 1000.00	\$ 40000.00	\$ 41000.00
8. Services of Attendant		\$	\$	\$
9. Rehabilitation		\$	\$	\$

Carrier's Comments: Benefit adjustment reimbursement requested for \$13453.90 from 1/1/00 through 12/31/00.

Medical Deductible:

* Date(s) of Disability in Carrier's Comments Section.

I hereby certify the accuracy of all of the above statements.

SIGNATURE Susan Sunday

POSITION Clerk Typist

DATE 12/31/01

NOTICE TO EMPLOYEE: With the final payment of compensation (as indicated hereon) on your industrial injury of / / , month day year identified as Case No. , the case shall be closed. This determination shall not constitute a bar to your reopening rights as provided by Section 386-89, HRS, nor to future medical benefits.