STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-5
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

Instructions

IMPORTANT:
If the information provided is incomplete, this claim will not be processed and will be returned to the employee. Please complete the form and submit to the appropriate District Office (see next page). You may create a copy for your record.

Ensure that the information indicated is CLEAR, LEGIBLE, COMPLETE, AND ACCURATE.

INJURED PERSON:
Name: Enter the full name as shown on the injured person's Social Security ID card (no nicknames).
Address: Enter the injured person's mailing address.

EMPLOYER:
Name: Enter the complete business name of the employer.
Address: Enter the full address of the employer including the city, state, and zip code.

INSURANCE CARRIER:
Name: Enter the name of the Workers' Compensation insurance for the employer.

INJURY:
Date of Accident: Enter the specific date that the injury occurred.
Time: Specify the time that the injury occurred and include A.M. or P.M.
Describe Injury/Illness: How and where did the accident occurred?
Reason for Filing: Specify reason(s) for filing this claim.

WITNESS:
Enter the name and address of individual(s) who saw the accident, if any.

NOTICE:
Indicate whether you notified your employer of the injury.

ATTENDING PHYSICIAN:
Enter the name and address of the physician who treated you for this injury and attach any available medical reports related to this claim.

REPRESENTED BY:
Enter the name and address of your attorney/union agent, or other representative. You may leave this section blank if you are not represented.

Address: Enter the full address of your representative including the city, state, and zip code.

SIGNATURE OF CLAIMANT:
Sign your name and date.

ATTACHMENTS: (if available)
(i.e. Physician's medical report, attorney's letter of representation, etc.)

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail, In-Person, or via Fax

Department of Labor and Industrial Relations, Disability Compensation Division

Oahu	Kauai	Maui
Princess Keelikolani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaii 96813 Mailing Address: P.O. Box 3769 Honolulu, Hawaii 96812-3769 Phone: (808) 586-9161 Fax: (808) 586-9219	3060 Eiwa Street, Room 202 Lihue, Hawaii 96766 Phone: (808) 274-3351 Fax: (808) 274-3355	2264 Aupuni Street, #2 Wailuku, Hawaii 96793 Phone: (808) 984-2072 Fax: (808) 984-2071
Hawaii	**West Hawaii**	
75 Aupuni Street, Room 108 Hilo, Hawaii 96720 Phone: (808) 974-6464 Fax: (808) 974-6460	Ashikawa Building 81-990 Halekii Street, Room 2087 Kealakekua, Hawaii 96750 If Mailing, Please Mail to This Address: P.O. Box 49, Kealakelua, Hawaii 96750 Phone: (808) 322-4808 Fax: (808) 322-4813	

☐ NEW
☐ AMEND

STATE OF HAWAII
DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

WC-5 EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION
NOTE: COMPLETE THE FILLABLE-DARK SHADED BLOCKS

CASE NUMBER
DATE RECEIVED

INJURED PERSON - SECTION 1

LAST NAME	FIRST	M.I.	SUFFIX	IDENTIFICATION TYPE ☐ SSN ☐ PASSPORT IDENTIFICATION NUMBER

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE

EMAIL ADDRESS	PHONE NUMBER	OCCUPATION	DATE OF BIRTH	SEX/GENDER
	( ) -			☐ MALE ☐ FEMALE

IS A TRANSLATOR REQUIRED FOR HEARING? ☐ NO ☐ YES	IF YES, WHAT LANGUAGE?	ACCESSIBILITY SERVICES - Please describe

EMPLOYER WHEN INJURED - SECTION 2

EMPLOYER NAME	NATURE OF BUSINESS

EMPLOYER ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE

POINT OF CONTACT	JOB TITLE	PHONE NUMBER	EMAIL ADDRESS
		( ) -	

DATE HIRED	WAS JOB ☐ FULL TIME ☐ PART TIME ☐ VOLUNTEER	GROSS PAY (BEFORE TAXES)	HOW OFTEN PAID?	WAS EMPLOYEE FURNISHED MEALS, TIPS, OR LODGINGS? ☐ NO ☐ YES

LOST TIME OFF FROM WORK AT THE OTHER EMPLOYMENT(S) AS A RESULT OF INJURY/ILLNESS? ☐ NO ☐ YES

INJURY/ILLNESS (I/I) - SECTION 3

DATE OF I/I	TIME OF I/I	TIME OF DAY ☐ AM ☐ PM	DATE DISABILITY BEGAN	ON EMPLOYER'S PREMISE ☐ NO ☐ YES	

IF NOT ON EMPLOYER'S PREMISES, INDICATE PLACE WHERE INJURY/ILLNESS OCCURRED	CITY	STATE	ZIP CODE

A. DESCRIBE HOW INJURY/ILLNESS OCCURRED - Please continue in Supplemental Section if additional space is needed.

B. DESCRIBE INJURY/ILLNESS - Please continue in Supplemental Section if additional space is needed.

C. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF BODY AFFECTED - Please continue in Supplemental Section if additional space is needed.

MULTIPLE BODY PARTS? ☐ NO ☐ YES

CASE NUMBER

#	SIDE OF INJURY/ILLNESS				PART(S) OF BODY	DISFIGUREMENT		BURN	
1.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
2.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES
3.	☐ LEFT	☐ RIGHT	☐ FRONT	☐ BACK		☐ NO	☐ YES	☐ NO	☐ YES

D. REASON FOR FILING - If OTHERS, please continue in Supplemental Section if additional space is needed.

☐ EMPLOYER HAS NOT FILED WC-1 ☐ INSURANCE CARRIER HAS NOT PAID BENEFITS ☐ REOPENING OF OLD CLAIM ☐ OTHERS-Explain below

STOP WORKING? ☐ NO ☐ YES		IF YES, GIVE DATE	
RETURNED TO WORK? ☐ NO ☐ YES		TYPE OF WORK DUTY	☐ REGULAR WORK ☐ LIMITED DUTY

WITNESS(ES) - SECTION 4

WAS THERE MORE THAN ONE (1) WITNESS? ☐ NO ☐ YES

1.	WITNESS 1 NAME – LAST	FIRST	M.I.	SUFFIX	
	ADDRESS	CITY	STATE	ZIP CODE	
	EMAIL ADDRESS	WORK PHONE NUMBER ( ) –	HOME PHONE NUMBER ( ) –		
2.	WITNESS 2 NAME – LAST	FIRST	M.I.	SUFFIX	
	ADDRESS	CITY	STATE	ZIP CODE	
	EMAIL ADDRESS	WORK PHONE NUMBER ( ) –	HOME PHONE NUMBER ( ) –		

NOTICE - SECTION 5

DID YOU NOTIFY THE EMPLOYER OF THE INJURY/ILLNESS? ☐ NO ☐ YES	IF YES, HOW? ☐ ORAL ☐ WRITTEN	IF SO, WHEN WAS THE DATE OF NOTIFICATON?	TIME OF NOTIFICATION	TIME OF DAY ☐ AM ☐ PM	
TO WHOM				PHONE NUMBER ( ) –	

INSURANCE CARRIER - SECTION 6

NAME OF WC INSURANCE CARRIER	POINT OF CONTACT	PHONE NUMBER	EMAIL ADDRESS
		( ) –	

INSURANCE CARRIER ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE

ATTENDING/TREATING PHYSICIAN - SECTION 7

NAME OF PHYSICIAN	PHONE NUMBER	EMAIL ADDRESS
	( ) –	

ADDRESS	CITY	STATE	ZIP CODE

NAME OF MEDICAL FACILITY	ADDRESS	CITY	STATE	ZIP CODE

DATE OF FIRST TREATMENT	FIRST TREATMENT			
		☐ NONE RECEIVED	☐ EMERGENCY ROOM	☐ DOCTOR'S OFFICE
		☐ CLINIC/HOSPITAL/URGENT CARE	☐ HOSPITAL STAY OVER 24 HOURS	

STILL BEING TREATED? ☐ NO ☐ YES

SIGNATURE - SECTION 8

I hereby present my claim for compensation for disability resulting from the foregoing injury/illness arising out of and in the course of my employment and not caused by my intoxification nor by my willful intention to injure myself or another individual.

I hereby authorize any physician and/or hospital to release any information related to any treatment rendered to me.

PRINT NAME OF EMPLOYEE	SIGNATURE TYPE ☐ EMPLOYEE ☐ REPRESENTATIVE	SIGNATURE	DATE

REPRESENTED BY (ATTORNEY/REPRESENTATIVE)	PHONE NUMBER	EMAIL ADDRESS
	( ) –	

ATTORNEY/REPRESENTATIVE ADDRESS	CITY	STATE	ZIP CODE

CASE NUMBER

SUPPLEMENTAL - SECTION 9

A. DESCRIBE HOW INJURY/ILLNESS OCCURRED (continued from Section 3.A)

B. DESCRIBE INJURY/ILLNESS (continued from Section 3.B)

C. DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF BODY AFFECTED (continued from Section 3.C)

D. OTHER REASON FOR FILING (continued from Section 3.D)

ENGLISH	This document contains important information. If you need language assistance at no cost to you, please contact us by telephone or in person immediately.
ILOKANO	Daytoy nga dokumento ket addaan ti importante nga impormasyon. No masapul mo ti mangipatarus nga libre, pangngaasim ta awagan na kami ti telepono wenno umay na kami kitaen nga daras.
TAGALOG	Ang dokumentong ito ay naglalaman ng importanteng impormasyon. Kung nangangailangan kayo ng libreng tulong para maintindihan ito, mangyaring makipag-ugnay sa amin sa pamamagitan ng telepono o makipagkita kaagad sa amin.
CHINESE SIMPLIFIED	此文件有重要信息。如果您需要免费的语言协助服务，请您立刻给我们打电话或来我们办公室请求帮助。
CHINESE TRADITIONAL	此文件有重要信息。如果您需要免費的語言協助服務，請您立刻給我們打電話或來我們辦公室請求幫助。
SPANISH	Este documento contiene información importante. Si necesita los servicios de un intérprete sin costo alguno para usted, por favor llame de inmediato por teléfono o contacte con alguna persona de nuestra oficina.
JAPANESE	この書類には重要な情報が含まれています。無償で日本語の支援を受けたい場合は、早急に電話あるいは直接窓口にて申込を行ってください。
CHUUKESE	Mei auchea met masowan ei taropwe. Ika pwe ke mochen aninis ren noumw chon chiaku esap kamo, kose mochen kokori kich won tengwa ika fen pusin chuto rech.
MARSHALLESE	Ilo pepa in ewor melele ko aorok. Ne kwoj aikuj jiban na ukok ilo ejjelok wonen, jouj im kokkeitaak kem ilo talboon ak ilo wobij e ien eo emakaaj tata.
KOREAN	이 문서는 중요한 정보가 포함되어 있습니다. 무료로 언어 도움이 필요하시면, 바로 전화 하시거나 오셔서 상담하십시오.
VIETNAMESE	Tài liệu này bao gồm các thông tin quan trọng. Nếu bạn cần hỗ trợ ngôn ngữ miễn phí, xin vui lòng đến gặp trực tiếp chúng tôi hoặc liên lạc qua điện thoại ngay lập tức.