NEW HAMPSHIRE MOTOR TRANSPORT ASSOCIATION

WORKERS' COMPENSATION CLAIMS MANUAL

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FILING AN EMPLOYER'S FIRST REPORT OF INJURY

An employee injured on the job must report any and all injuries immediately to a supervisor or foreman.

The employer must then report the injury to New Hampshire Motor Transport within **five (5)** calendar days of notification. Failure to do so may result in the assessment of a civil penalty to the employer of up to $2,500. at the discretion of the Labor Commissioner. Please note that Box 22 on the First Report of Injury (date supervisor/employer was first notified) is the date used by the Dept of Labor in calculating the five day reporting requirement.

Note: 1 Be sure to complete the form in its entirety, indicating N/A in the boxes not applicable to the claim.

2. Indicate whether or not the employee has returned to work, and if so, when.

3. Please make sure the employee's correct street address and phone # are included

Email or ***fax*** a copy of the report the day you complete it to:

Fax: 603-415-8344 or 603-415-8345 or 603-415-0768

Email: julia@nhmta.org ***and*** craig@nhmta.org.**and/or** betty@nhmta.org

or

Mail: NHMTA

P.O. Box 3898

Concord, N.H. 03302

NHMTA will electronically file the report for you with the Dept. of Labor.

Retain a copy for your records.

FIILING AN EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY (13 WCA)

Supplemental Report of Injury should be filed when:

1) Employee is disabled from work for 4 days or more.
2) A subsequent disability occurs due to the original injury after a no lost time claim
3) A reoccurrence of a prior injury necessitates further disability
4) Must be filed the day the employee returns to work.

Revised July 2017 (2)

NH DOL USE ONL

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

Return to: **The State of New Hampshire, Department of Labor**
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

***IMPORTANT**; Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

1. Name of injured: First / Middle Initial / Last			2. DOB:	3. Age:	4. Male ☐ Female ☐ / 5. SS No.:
6. Address: No. & St. / City/Town			7. State:	8. Zip Code:	9. Tel. No.:
10. Is there on file a N.H. Youth Employment Certificate?:	11. Occupation when injured:	12. Was this his/her regular occupation? If not, state regular occupation:		13. Wages per hr.:	14. No. hrs. worked pe day:
15. No. days worked per week:	16. Average Weekly Earnings:	17. Was injured hired in N.H. ?	18. Date employment began:		19. Date & Time of Injury:
20. Date disability began:	21. Was injured paid in full for this day?	22. Date supervisor/employer was first notified:	23. Name of Person notified:		24. Location/Jobsite where acciden occurred:
25. Describe fully how accident occurred and describe what employee was doing when injured:					
26. Name of witness(es):			27. Part(s) of body injured:		28. Estimated length of disability
29. Has injured return to work?	30. If so, what date?	31. At what occupation or job?			32. Returned at: Full Duty: Alternative/Light Duty:_____
33. Equipment causing injury:		34. Were safeguards in place?			35. Was accident caused by injured's failure to use safeguards or follow regulations?
36. Initial Treatment: (check those that apply) No medical treatment: ☐ Care provide by Employer only (on-site): ☐ Emergency Care: ☐ Hospitalized: ☐ Other: (Outpatient): ☐ (Clinic): ☐ (Office Visit): ☐ (Other-explain): _____					
37. Name of treating physician: / Name of treating hospital:					38. Has injured died?, If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name:	40. Employers Federal ID:		41. If leased or temporary worker, client's business nam
42. Business Address of No. 39 above:		43. City/State:	44. Zip:
45. Telephone Number:	46. Insurance Co. (**not agent**) or Self Insured Group: New Hampshire Motor Transport Association		47. Managed Care Program? X Y or ☐ N. If yes, nar Provider: Genex
48. No. of Employees: Full-time: / Part-Time:	49. Is there a Written Safety Program **in force**? Yes		50. Is there an **active** Safety Committee? Yes
Business SIC Code	52. Type or Nature of Business in N.H.:	53. If report sent by Insurance Agency, state name:	
54. Employer Signature:		55. Printed/Typed Name and Official Title:	
56. Employee Signature (**whenever** possible):		57. Date of this report:	

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._____

FILING A WAGE SCHEDULE

Once an employee is out of work for 14 days or more, this form needs to be completed. You must list the wages earned for the 26 weeks prior to the date of injury. Do not use the earnings for the week that the injury occurred. If the employee has worked less than 26 weeks, list all the earnings for the weeks they have worked. The State Form 76 WCA is available online at http://www.labor.state.nh.us or you can use a copy of the form in this manual.

The average weekly wage is computed by adding the total wages and dividing by the number of weeks of wages. The compensation rate is 60% of the computed average weekly wage.

Once the Wage Schedule has been completed forward to NHMTA, we will file with the Department of Labor. ***The compensation rate is based on a 7 day work week, in accordance with the NH State Law.*** When an employee is deemed by a physician to be disabled over a weekend or holiday, those days must be included in the period of disability.

There is a three day waiting period before compensation for a work-related injury is paid to the employee (see schedule). After an employee has lost 14 days, compensation is paid retroactive to the first day. Compensation will be paid in accordance with the following schedule:

1 day out of work = No compensation paid	8 days out of work = 5 days paid
2 days out of work = No compensation paid	9 days out of work = 6 days paid
3 days out of work = No compensation paid	10 days out of work= 7 days paid
4 days out of work = 1 day compensation paid	11 days out of work= 8 days paid
5 days out of work = 2 days compensation paid	12 days out of work =9 days paid
6 days out of work = 3 days compensation paid	13 days out of work =10 days paid
7 days out of work= 4 days compensation paid	14 days out of work=14 days paid

Alternative Work Opportunities – All employers with 5 or more employees shall develop temporary alternative work opportunities for injured employees. If the employee fails to accept temporary alternative work, we can file a petition with the Dept. of Labor to reduce or end compensation.

If an injured employee returns to temporary alternative work within 5 days of sustaining the injury, such employee shall be paid workers' compensation from the first date of the injury (three day waiting period is waived).

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 BOTH COPIES OF THIS SCHEDULE AND CARRIER'S COPY OF THE SUPPLEMENTAL REPORT FORM NO. 13 WCA NO LATER THAN EMPLOYEE'S FIFTEENTH DAY OF DISBAILITY RESULTING FROM INDUSTRIAL ACCIDENT.

THIS WAGE SCHEDULE IS FOR 26 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 EARNINGS	2 OTHER ADVANTAGES (See Wages Definition)	3 TOTAL Columns 1 & 2
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				

WAGES:

In addition to money payments, means reasonable value of board, rent, housing, lodging, fuel or similar advantage received from the employer, and gratuities received in the course of employment for others, but not including any sum paid by the employer to cover any special expenses entailed on the employee by the nature of his employment.

Please provide a brief explanation for weeks with no wages.

RSA 281-A:2, Par. XV.

Carrier Name_____

Address_____
(Title)

Dept. Approval_____

_____
(Employer's Signature)

_____

Date _____

NEW HAMPSHIRE MOTOR TRANSPORT ASSOCIATION
ACCIDENT/INCIDENT INVESTIGATION REPORT

Member Company:_____ Time:_____ AM PM

Date of Injury:_____Employee Involved: _____

Date Employed:_____ Job Classification: _____

Department: _____ Building/premises/location of accident/incident:_____

Did the accident/incident result in injury? _____ Witnesses: 1)_____

First Aid Administered? Yes_____ No_____ 2)_____
If yes, when and by whom? _____

Nature and Extent of Injury: (burn, fracture, laceration etc.) _____
_____

Date Injury was first reported: _____ To Whom: _____

Description of accident/injury: _____
_____
_____

Was this accident preventable?_____ Yes _____ No

Recommendations to prevent reoccurrences: _____
_____

What corrective action has been taken?: _____
_____

Employee Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

SAFETY COMMITTEE'S REVIEW AND COMMENTS

Does this accident producing condition exist in other areas/facilities? Yes _____ No _____
If so, have the other areas/facilities been notified of the condition? Yes _____ No _____
Was corrective action proper? Yes _____ No _____

Safety Committee review date: _____

Safety Committee Chairperson/Representative's Signature: _____

EXETER REVIEW

Corrective Action Approved: Yes _____ No _____
Special orders/actions: _____
_____

INSTRUCTIONS FOR COMPLETING ACCIDENT INVESTIGATION REPORT

Note to Supervisor:

Remember an accident investigation is performed to help eliminate or minimize the potential for the same accident reoccurring. **It is not intended to find fault or blame.** A true accident/incident analysis seeks to determine the true cause or causes that can be controlled or eliminated. When completing your investigation, be sure to answer these questions:

Who was injured?

How did it happen?

Where did it happen?

When did it happen?

What materials, equipment or conditions were involved?

Was it preventable?

Were there any witnesses?

How will it be remedied?

Note to Safety Committee:

No investigation is complete unless a corrective measure or action is taken to eliminate or reduce the potential for recurrence. Determine it the condition exists elsewhere in your operation and notify the affected Department(s) to help prevent a similar accident.

Note to Executive:

Authorization for corrective action is your responsibility! Be sure to provide your employees with a safe place to work!

SAFETY IS NO ACCIDENT!

NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE

The employee should complete the Notice of Accidental Injury or Occupational Disease and retain a copy for his/her records. The purpose is to provide a record that the injury/incident was reported for the benefit of the employee.

Place a copy in the employee's Personnel File, and send NHMTA a copy of the completed form along with the First Report of Injury (8 WC). Although this form is not required by the Department of Labor, it is required of all NHMTA members.

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
SPAULDING BUILDING
95 PLEASANT STREET
CONCORD, NEW HAMPSHIRE

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)

MEMO OF PAYMENT

A Memo of Payment is completed each time indemnity benefits are paid to an injured employee. One is also completed whenever the indemnity benefit status changes or when benefits are discontinued following a return to work.

MEMO OF DENIAL

This form is used when a claim is denied. It is sent to the Department of Labor and the employee, stating the reason for the denial.

Should an employee dispute that decisi on, he or she may petition the Commissioner of Labor in writing to request a hearing. The employee has 18 months after receiving notice that the claim has been denied to request a hearing. The presiding Department of Labor Hearings Officer will give full consideration to all evidence presented.

The employee may retain an attorney to represent his/her interest before the Hearings Officer. A New Hampshire Motor Transport representative and an attorney will be present to represent the interest of the employer.

A decision by the Hearings Officer will be rendered within 30 days of the hearing. If there still remains a dispute, then either the employee or NHMTA may appeal the decision to the Compensation Appeals Board.

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

CONCORD, NH 03301

MEMO OF PAYMENT OF DISABILITY COMPENSATION

You are required to pay total disability compensation and to file, with the department, copy to employee, memorandum of payment in accordance with RSA 281-A:40, 41 and 42 **as soon as possible after date of knowledge of disability of four or more days, but no later than seven days thereafter.** Filing shall also be made upon making provisional payment, upon adjusting such payment, upon making last payment, and upon making payment resulting from departmental hearing. **Failure to pay and to file memorandum promptly, in the absence of a legitimate denial of benefit, shall render a carrier liable to a civil penalty of up to $2,500.**

Employee _____ _____
(Name) (Soc. Sec. No.)

Employer _____ _____
(Name) (Federal Identification No.)

Carrier _____ _____
(Name) (Carrier Number Assigned by DOL)

Date of:

Injury	Disability/Recurrence*	First or Sup. Rep. R'cd	First Payment	Last Payment

*Recurrence refers to subsequent periods of disability

1

Compensation at the rate of $_____ per week
Beginning _____ Avg. WKly. Wage of $_____

Check box if compensation payment results from department hearing decision ☐
Chck box if memo indicating provision payment already filed ☐
Check box if memo indicating adjustment in total disability – RSA 281-A:29 ☐
SEE ATTACHED WAGE SCHEDULE, EXCEPT IF DISABILITY OF LESS THAN FOURTEEN DAYS

2

Missing Wage Schedule

When Expected _____

Provisional Payment of $ _____ Subject to Later Adjustment

3

Total Compensation Paid $ _____ Ending Date _____

Date of Return to Work _____ Earning after R.T.W._____

Name of Employer (New or same) _____

_____ _____
(Date) (Signature)

9 WCA (6-94)
P&P WHSE STOCK #4610

Dept. Approval

Memo of Denial of Workers' Compensation Benefits

Claimant's Name _____ Social Security No. _____

Employer _____ Identification No. _____

Date of Accident _____ Date First Report Received _____

YOUR CLAIM TO WORKERS' COMPENSATION BENEFITS IS HEREBY DENIED BY EMPLOYER OR CARRIER FOR REASONS INDICATED BELOW. IF YOU SO ELECT, YOU MAY PETITION THE COMMISSIONER OF LABOR, 95 PLEASANT ST., CONCORD NEW HAMPSHIRE, 03301, IN WRITING FOR A HEARING. YOU MUST REQUEST A HEARING WITHIN 18 MONTHS OF THE DENIAL.

REASONS

1. ☐ No Employer-Employee Relationship (pars. VII, VIII, IX, RSA 281-A:2)
2. ☐ No Causal Relationship to Employment (pars. XI, XIII, RSA 281-A:2)
3. ☐ Employee's Fault (RSA 281-A:14)
4. ☐ Improper Notice of Injury by Employee (RSA 281-A:19, 20, 21)

Explanation

_____

_____

_____

_____

_____

_____

Authorized Representative_____

Insurance Carrier and Number_____

Carrier's Address and Phone #_____

Date_____

9 WCA-1 (9-02) White – Labor Dept. Canary – Insurance Claims Office Pink – Employee's Copy

N.H. WORKERS' COMPENSATION MEDICAL FORM (75WCA-1)

When an employee has reported a work related injury and requires medical treatment the employer should provide them with this form prior to seeking treatment whenever possible.

This form is completed by the medical provider who renders treatment to an injured worker. The provider is responsible for distribution of this form as follows:

White copy: faxed and/or mailed to NHMTA

Pink copy: given to the injured worker

Yellow copy: retained by the provider

The injured worker is required to give a copy of this form to their employer within 24 hours of their medical treatment. This procedure should be followed after each follow-up appointment with the treating provider.

Exceptions to this rule:

1) Any type of Therapy (PT, OT, ST)

2) Diagnostic Testing

3) Chiropractic / Acupuncture Services:
Expect a NHWC Medical Form to be completed:

a) at the initial visit

b) any significant change in medical condition or disability status

c) at time of discharge

NEW HAMPSHIRE WORKERS' COMPENSATION MEDICAL FORM

This form must be completed at each health professional visit (MD, DO, DC or DDS) and must be filed with the workers' compensation insurance carrier within 10 days of the treatment (first aid excluded). Failure to comply and complete this form shall result in the provider not being reimbursed for services rendered and may result in a civil penalty of up to $2,500.

In compliance with RSA 281-A:23-b, the employer with 5 or more employees must provide temporary alternative/transitional work opportunities to all employees temporarily disabled by a work related injury or illness.

Employee_____ Employer_____

SS#_____ Work telephone #_____

Occupation_____ Employer contact_____

Date last worked_____ Employer address_____

W.C. insurer_____ _____

HEALTH PROFESSIONAL TO COMPLETE

☐ Initial visit ☐ Follow-up visit Date of Injury_____ Time_____

Worker's statement of the incident_____

Worker's complaints_____

Diagnosis/Prognosis_____

Treatment plan_____

_____

In your opinion is this injury and disability as a result of injury described above? ☐ Yes ☐ No ☐ Unclear

EMPLOYEE WORK CAPABILITY

☐ Continue Working Can return to work: ☐ Yes Date_____ ☐ No

☐ Full Duty ☐ With Modification. If so, for what duration?_____

Employee Can	No Restrictions		Frequently	Occasionally	Unable to
bend					
kneel					
squat					
climb					
stand					
walk					
sit					
reach					
drive					
do fine motor					
		Wrist	Elbow	Shoulder	Ankle
No repetitive motions	Right				
	Left				

Employee can lift/carry maximally _____ lbs.
Employee can lift/carry frequently _____ lbs.

Employee can work a maximum of #_____ hours/day, #_____ days/wk.
What special accommodations are required?_____

_____

Other_____
Has employee reached maximum medical improvement?
☐ Yes ☐ No
Has injury caused permanent impairment?
☐ Yes ☐ No ☐ Undetermined

ALL MEDICAL NOTES MUST BE ATTACHED TO BILL

I certify that the narrative descriptions of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of my knowledge.

_____ _____ _____
Provider's signature Provider's Printed name Provider's telephone #

_____ _____
Federal ID# Date of Visit

MEDICAL AUTHORIZATION: The act of the worker in applying for workers' compensation benefits constitutes authorization to any physician, hospital, chiropractor, or other medical vendor to supply all relevant medical information regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, and the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. [281-A:23 V(a)]

75 WCA-1 (06/94) White – Insurer/Managed Care Yellow – Provider Pink – Employee/Employer

SECOND INJURY FUND

If an employee who has a permanent physical or mental impairment from any cause or origin incurs a subsequent disability by injury arising out of and in the course of such employee's employment, the claim may qualify for reimbursement, of a portion of the benefits paid, through a special fund established by the State called the Second Injury Fund.

The two qualifying factors to establish for consideration to be given by the State for reimbursements through the fund are:

1) There must be written records that the employer had knowledge of the employee's permanent physical or mental impairment at the time that the employee was hired or at the time that the employee was retained in employment after the employer acquired such knowledge.

2) There must be medical evidence that the combination of the new injury and the pre-existing condition has caused greater disability.

USING THE SECOND INJURY FUND FORM

The Second Injury Fund Information form will assist you in documenting pre-existing medical conditions at the time of hire. The following steps should be used when having your employees complete the Second Injury Fund Form:

1) Offer of employment has been extended and accepted.

2) **Second Injury form can be added to employee's enrollment package for their review and consideration only. Per the DOL, it is no longer acceptable to have the employee complete the form. The employer can only ask the employee the questions and then the employer must fill in their response, sign and date the form in order to be used as employer knowledge for purposes of qualifying for SIF reimbursement.** (Revised July 2017)

3) Second Injury form should be provided to all new hires, not selectively given.

4) Advise employee the Second Injury form is confidential.

5) Second Injury form is to be kept separate from the personnel file.

6) If employee has a work related injury, New Hampshire Motor Transport may request a copy as proof that the employer had knowledge of a pre-existing condition.

SECOND INJURY FUND
EMPLOYEE INFORMATION FORM

Employee: Date:
Position: **Date of Hire:**

We require the following in order to satisfy our obligations under the New Hampshire Workers' Compensation Law, RSA 281-A. In order to apply for reimbursement from the Second Injury Fund in the event that you may suffer a work-related injury while employed with us, we must have written documentation of any physical or mental impairment that you may have suffered. This documentation and any related information that you provide in connection with this inquiry will be maintained confidentially and separately from your employee personnel file. Disclosing a prior impairment on this form will not impact your eligibility to receive worker's compensation benefits.

This document and any related information that you provide in connection with this inquiry will only be used as permitted under the Americans with Disabilities Act and New Hampshire Workers' Compensation Law.

Please identify any prior or current physical or mental impairments, whether work related or not, including, but not limited to, high blood pressure, diabetes, respiratory or cardiovascular concerns, prior back injuries, and any surgical procedures. Attach additional pages, if necessary.

Nature of Injury Or Impairment	**Date of Origin**	**Name & Address Of Treating Provider**	**Workers' Compensation? (Yes or No)**	**If Yes, Name & Address of Employer**

☐ Please check here if you have no history of significant Injuries or Illnesses.

I certify that all of the information that I provide on this Second Injury Information Form is complete, true, and accurate. I understand that if I have any questions about this Form, I may direct them to _____

Signature: Date:

Witness:

Please note that the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SECOND INJURY FUND
EMPLOYEE INFORMATION FORM

******Click on PDF Icon to get PDF document**

Page 17 - SIF EE
info Form.pdf

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

NH DOL USE ONLY

Return to: **The State of New Hampshire, Department of Labor**
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

IMPORTANT: *Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

1. Name of injured: First / Middle Initial / Last
2. DOB:
3. Age:
4. Male _ _ Female _ _
5. SS No.:
6. Address: No. & St. / City/Town
7. State:
8. Zip Code:
9. Tel. No.:
10. Is there on file a N.H. Youth Employment Certificate?:
11. Occupation when iniured:
12. Was this his/her regular occupation? If not, state regular occupation:
13. Wages per hr.:
14. No. hrs. worked per day:
15. No. days worked per week:
16. Average Weekly Earnings:
17. Was injured hired in N.H.?
18. Date employment began:
19. Date & Time of Injury:
20. Date disability began:
21. Was injured paid in full for this day?
22. Date supervisor/employer was first notified:
23. Name of Person notified:
24. Location/Jobsite where accident occured:
25. Describe fully how accident occurred and describe what employee was doing when injured:
26. Name of witness(es):
27. Part(s) of body injured:
28. Estimated length of disability:
29. Has injured returned to work?
30. If so, what date?
31. At what occupation or job?
32. Returned at: Full Duty: ___ ___ Alternative/Light Duty: ___ ___
33. Equipment causing injury:
34. Were safeguards in place?
35. Was accident caused by injured's failure to use safeguards or follow regulations?
36. Initial Treatment: (check those that apply) No medical treatment: _ _ Care provide by Employer only (on-site): _ _ Emergency care: _ _ Hospitalized: _ _
Other: (Outpatient): _ _ (Clinic): _ _ (Office Visit): _ _ (Other-explain): _____
37. Name of treating physician: / Name of treating hospital:
38. Has injured died? If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name:
40. Employers Federal ID:
41. If leased or temporary worker, client's business name:
42. Business Address of No. 39 above:
43. City/State:
44. Zip:
45. Telephone Number:
46. Insurance Co. (**not agent**) or Self Insured Group:
47. Managed Care Program? Y or N. If yes, name Provider:
48. No. of Employees: Full-time: / Part-time:
49. Is there a Written Safety Program **in force**?
50. Is there an **active** Safety Committee?
51. Business SIC Code
52. Type or Nature of Business in N.H.:
53. If report sent by Insurance Agency, state name:
54. Employer Signature:
55. Printed/Typed Name and Official Title:
56. Employee Signature (**whenever** possible):
57. Date of this report:

Form 8WC (7-95) White – Labor Department Canary – Insurance Claims Office Pink – Employer's Copy

FILING AN EMPLOYER'S FIRST REPORT OF INJURY

An employee injured on the job must report any and all injuries immediately to a supervisor or foreman.

The employer must then report the injury to New Hampshire Motor Transport within **five (5)** calendar days of notification. Failure to do so may result in the assessment of a civil penalty to the employer of up to $2,500. at the discretion of the Labor Commissioner. Please note that Box 22 on the First Report of Injury (date supervisor/employer was first notified) is the date used by the Dept of Labor in calculating the five day reporting requirement.

Note: 1 Be sure to complete the form in its entirety, indicating N/A in the boxes not applicable to the claim.

2. Indicate whether or not the employee has returned to work, and if so, when.

3. Please make sure the employee's correct street address and phone # are included

Email or ***fax*** a copy of the report the day you complete it to:

Fax: 603-415-8344 or 603-415-8405 or 603-415-0768

Email: julia@nhmta.org ***and*** deanna@nhmta.org.

or

Mail: NHMTA

P.O. Box 3898

Concord, N.H. 03302

NHMTA will electronically file the report for you with the Dept. of Labor.

Retain a copy for your records.

FIILING AN EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY (13 WCA)

Supplemental Report of Injury should be filed when:

1) Employee is disabled from work for 4 days or more.
2) A subsequent disability occurs due to the original injury after a no lost time claim
3) A reoccurrence of a prior injury necessitates further disability
4) Must be filed the day the employee returns to work.

Revised July 2017