OFFICE OF RISK MANAGEMENT
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040
(225) 342-7565

EMPLOYER REPORT OF INJURY / ILLNESS LDOL-WC-1007

Employee Social Security Number
Employer UI Account Number
Employer Federal ID Number
Location Code

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately. Forms for cases resulting in more than 7 days of disability or death are to be sent to the OWCA by the 10th day after the Incident or as requested by the OWCA.

PURPOSE OF REPORT: (Check all that apply)

- ☐ More than 7 days of disability
- ☐ Injury resulted in death
- ☐ Amputation or disfigurement
- ☐ Possible dispute
- ☐ Lump Sum Compromise/Settlement
- ☐ Other
- ☐ Medical Only (no copy needed by OWCA)

1. Date of Report MM/DD/YY	2. Date / time of injury: MM/DD/YY Time ☐ AM ☐ PM	3. Normal Starting Time Day of Accident: ☐ AM ☐ PM	4. If Back to Work Give Date MM/DD/YY	5. At same Wage? ☐ Yes ☐ No	DO NOT WRITE IN THIS COLUMN
6. If Fatal injury, Give Date of Death: MM/DD/YY	7. Date Employer Knew of injury: MM/DD/YY	8. Date Disability began: MM/DD/YY	9. Last Full Day Paid MM/DD/YY		Date Received
10. Employee Name: First Middle Last		11. ☐ Male ☐ Female	12. Employee Phone # ( ) -		S.I.C.
13. Address and Zip Code			14. Parish of Injury		State-Parish
15. Date of Hire	16. Age at illness/injury	17. Occupation	18. Dept./Division Employed:		Occupation
19. Place of Injury-Employer's Premises ? ☐ Yes ☐ No	20. If No, indicate Location-Street, City, Parish and State				Nature
21. What work activity was the employee doing when the incident occurred ? (Give weight, size and shape of material or equipment involved. Tell what he was doing with them. Indicate if correct procedures were followed.)					Part of Body
					Source
					Event
					NCC:

22. What caused the incident to happen? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)

23. Part of body injured and Nature of Injury or Illness(ex. left leg: multiple fractures)	24. If Occ. Disease- Give Date Diagnosed

25. Physician and Address street city state zip	26. If Hospitalized, give name & address of facility
27. Employer's Name	28. Person Completing This Report – Please print
29. Employer's Address street city state zip	30. Employer's Telephone Number ( ) -
31. Employer's Mailing Address – If Different From Above city state zip	32. Nature of Business – Type of Mfg., Trade, Construction, Service, etc.

33. Wage Information Employee was paid ☐ Daily ☐ Weekly ☐ Monthly ☐ Other The average weekly wage was $ per week.

34. Verification of Employer Knowledge of this Report.

Name: Title: Date:

DA 1973
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OFFICE OF RISK MANAGEMENT
P.O. Box 94095
Baton Rouge, LA 70804-9095
Phone No. (225) 219-0168

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LDOL – WC – 1025 – ER
R 8/98

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of $500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to $ 10,000, imprisonment with or without hard labor for not more than I year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than $500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to $10,000, imprisoned with or without hard labor for up to I 0 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000.

EMPLOYER CERTIFICATION

I certify that I can read the English language, that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)	Signature	Date
Company Name	Company Address	
( ) -		
Phone Number	Insurance Policy Number	
	- -	
Employee Name	Employee Social Security Number	