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 WorkersComp@dol.nh.gov or mail to
NH Department of Labor Workers' Compensation Division 95 Pleasant St. Concord NH 03301