



**West Virginia Workers' Compensation  
Employers' Report of Occupational Injury**

PLEASE PRINT OR TYPE

Section I Employer Information		
Insurer: Zurich Insurance	Address: PO Box 968053 Schaumburg, IL 60196-8053	Site Code:
Policy Name: State of West Virginia Office of the Insurance Commissioner		FEIN:
Contact Email:	Telephone: ( ) -	

Section II Employee Information		
Name: (Last):	(First):	(M.I.):
Address:		Telephone: ( ) -
City:	State:	Zip: Social Security No.: - -
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status:
Injured Employee is (check all that apply): <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired – Date Retired:		Employee's Occupation/Job Title:

Section III Information Regarding Injury		
Date of Injury or Last Exposure:	Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Witnesses to Injury:
Date Employer Notified of Injury :	Supervisor to whom Injury Reported:	
If Injury was Fatal, Indicate Date of Death:		
Did Injury Occur on Employer's Property? <input type="checkbox"/> Yes <input type="checkbox"/> No Address or location where injury occurred:		
What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, etc.):		
How did the Injury Occur (be specific; include time that employee began work on the date of injury, any equipment, tools, substances or objects connected to the injury; attach additional sheet if necessary):		
Nature of Injury (cut, bruise, strain, etc.):		
Body Part(s) Injured:		
Are You Aware of, or Do You Suspect, a Prior Injury to this Body Part? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do You Have Reason to Question this Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "yes," attach a specific explanation to this form).		
Location of Initial Treatment:	Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section IV			Wage and Lost Time Information		
Date Hired:		Last Day Worked After Occupational Injury:			
Number of Work Days Lost:		Date of Return to Work:		Hours Worked per Week:	
Is Temporary Transitional Duty Available? <input type="checkbox"/> Yes <input type="checkbox"/> No			Wage on Date of Injury: \$ per: <input type="checkbox"/> hour <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month		
Are Wages Being Paid to Injured Employee During Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Employee has Returned to Work, is it Alternative or Modified Work? <input type="checkbox"/> Yes <input type="checkbox"/> No  If "yes," indicate current wage: \$ per: <input type="checkbox"/> hour <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month		
Daily rate of pay on the date of injury: \$ _____ and best quarter wages of preceding four quarters \$ _____					
I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically West Virginia Code §61-3-24e, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.					
Print Name: _____			Title: _____		
Signature: _____			Date: _____		