STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

West Virginia Workers' Compensation
Employers' Report of Occupational Injury

PLEASE PRINT OR TYPE

Section I	**Employer Information**	
Insurer: Zurich Insurance	Address: PO Box 66941 Chicago, IL 60666-0941	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: ☐ M ☐ F	Marital Status:	
Injured Employee is (check all that apply): ☐ Full-Time ☐ Part-Time ☐ Retired – Date Retired:		Employee's Occupation/Job Title:	

Section III	**Information Regarding Injury**
Date of Injury or Last Exposure: Time: ☐ a.m. ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No	
Do You Have Reason to Question this Injury? ☐ Yes ☐ No (If "yes," attach a specific explanation to this form).	
Location of Initial Treatment: Emergency Room? ☐ Yes ☐ No Hospitalized? ☐ Yes ☐ 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? ☐ Yes ☐ No	Wage on Date of Injury: $ per: ☐ hour ☐ day ☐ week ☐ month	
Are Wages Being Paid to Injured Employee During Disability? ☐ Yes ☐ No	If Employee has Returned to Work, is it Alternative or Modified Work? ☐ Yes ☐ No If "yes," indicate current wage: $ per: ☐ hour ☐ day ☐ week ☐ 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: _____