Workers' Compensation Commission (WCC)
Employers' Report of Injury
Prior To Completing This Form You Must
Read The Instructions On The Back Of This Form. **WC-3**

For Commission Use Only
Claim Number: _____
Team Assigned: _____
ICD9: _____

All Information Must Be Completed

I have been informed of my responsibilities under WV Workers' Compensation Law and agree to abide by such in the administration of services provided by the Commission. I am aware the law provides for severe penalties for providing false statements or information.
Initials of Employer Representative: _____

1. WCC Policy Number: _____ - _____ | FEIN or SSN: _____
2. Industrial Code: _____ | Phone Number: (_____) _____- _____
3. Name of Employer as Listed with WCC: _____
   Address of Employer: _____
   City: _____ County: _____ State: _____ Zip Code: _____
4. Injured Employee SSN: _____ - _____- _____ | Date of Injury: _____/ _____/ _____
5. Injured Employee Name: _____ | Marital Status: _____
   Job Title/Description: _____ | Telephone: _____
6. Address of Employee: _____
   City: _____ County: _____ State: _____ Zip Code: _____
7. Injured Employee Date of Birth: _____/ _____/ _____ | Sex: ☐ Male ☐ Female
8. Injured Employee is (Check All That Apply):
   ☐ Owner/Part Owner ☐ Full-Time ☐ Part-Time
   ☐ Officer ☐ Volunteer ☐ Leased (If Leased Employee, complete 8a, 8b, and 8c.)
   8a. Name and Policy Number of Leasing Company: _____
   8b. Name and Policy Number of Client Employer: _____
   8c. Date the injured worker was first assigned to the Client Employer: _____/ _____/ _____
9. If owner, part owner, or officer, are wages included on wage reports? ☐ Yes ☐ No
10. Date employee was first employed by you? _____/ _____/ _____
11. Stopped Work for Injury: Date _____/ _____/ _____ Time: _____ ☐ a.m. ☐ p.m.
    Date Employee Returned to Work: _____/ _____/ _____ Time: _____ ☐ a.m. ☐ p.m.
    Time Employee Began Work on Date of Injury: _____ ☐ a.m. ☐ p.m.
    Time of Injury: _____ ☐ a.m. ☐ p.m.
    Is the disability expected to last longer than four (4) days? ☐ Yes ☐ No
12. Do you have a Workers' Compensation Commission approved Return-To-Work program? ☐ Yes ☐ No
13. If employee has returned to work, is it alternate or modified work? ☐ Yes ☐ No
    If Yes, indicate wages: Hourly Rate: $_____ Hours per Week: _____
14. Daily rate of pay on the date of injury: $_____
15. If part-time employee: Hourly Rate: $_____ Hours per Week (25 or less) : _____
16. Did Injury Occur on Employer's Property? ☐ Yes ☐ No
    Address where injury occurred: _____
17. Nature, Body Part and Type of Injury:
    17a. Nature: _____
    17b. Body Part: _____
    17c. Type of Injury: _____
18. Do you have reason to question this injury? ☐ Yes ☐ No *If Yes, you must attach a specific explanation to this form.*
19. Was an incident report completed? ☐ Yes ☐ No *If Yes, see instructions.*
20. Initial Medical Contact: _____ | Phone Number: (_____) _____- _____
21. Are you aware of or suspect a previous injury to this body part? ☐ Yes ☐ No

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 § 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 by the Commission. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent to aid or abet anyone in securing or attempting to secure benefits to which he or she is not entitled.
Signature: _____ **Date:** _____/ _____/ _____

General Instructions for Completing the WC-3, "Employers' Report of Injury"

- Please Read Carefully -

General Overview: The claim initiation process now involves the filing of two individual forms:
WC-1, Employees' and Physicians' Report of Injury: To be completed by the injured worker and the medical provider.
WC-3, Employers' Report of Injury: To be completed by the employer

A claim cannot be established until the Workers' Compensation Commission has received at least one of the forms listed above. This form should not be used to file occupational pneumoconiosis or hearing loss claims.

Please note that W.V. Code 23-4-1 provides that employees of the state and its political subdivisions are ineligible to receive workers' compensation benefits while drawing sick leave benefits at the same time for the same reason. **The employee must make his/her choice known in Question 15 on the WC-1, Employees' and Physicians' Report of Injury form.**

To the Employer: W.V. Code 23-4-1b requires you to complete and submit the WC-3 form within five (5) days of receipt of notification of the employee's injury, or within five (5) days after the employer has been notified by the Commission that a claim for benefits has been filed on account of an injury. This information is used to assign the liability of the claim. After completing this form, make a copy for your records. If you have any questions, you may contact the Commission at 1-888-4WV-COMP, or 1-888-498-2667.

Question Number	Explanation
1.	Workers' Compensation Commission Policy Number indicated on your WCC wage reports and FEIN or Social Security number.
4.	Injured employee's Social Security number.
5.	Injured employee's Name, Marital Status, Job Title/Description, and Telephone number.
7.	Injured employee's Date of Birth and Gender.
8.	Leased employees are workers provided by one business to another business.
8a.	Leasing companies/employers provide workers to other businesses.
8b.	Client employers accept employees from leasing companies to work a specified period of time.
8c.	List the specific date the injured worker was first assigned to the Client Employer.
12.	The Return-to-Work Program must be approved by the Workers' Compensation Commission
14.	Enter the employee's daily rate of pay on the date of injury.
17a.	Define injury, i.e., sprain/strain, fracture, laceration.
17b.	Part(s) of body injured and how injury occurred, i.e., lifting, fall, motor vehicle accident.
19.	Attach copy to form. Fax or mail to Commission.
20.	Name of medical provider where injured employee first sought treatment.

Please mail the completed form to: **Workers' Compensation Commission**
P. O. Box 431
Charleston, WV 25322-0431

When completing this form, enclose attachments if additional space is needed.