THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
SPAULDING BUILDING
95PLEASANTSTREET
CONCORD, NEW HAMPSHIRE 03301

NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE SaWCA
(Please print or type)

To_____ Phone#_____
(Name of **Employer)**

_____
(Business Name and Address)

IN **ACCORDANCE WITH RSA 281-A:20,** This is to notify you that an injury occurred.

_____ SS#_____
(Name of Injured **Employee)**

_____ Daytime Phone#_____
(Address of Injured Employee)

_____
(Date of Accident or First Treatment)

_____
(Place Accident Happened)

Describe your injury or disease, and how it happened. Identify the body part(s) affected._____

_____

_____

_____

I have been unable to work since my injury. ☐ Yes ☐ No

I have incurred the following medical bills.

Name of Doctor	Dates of Service	Amount
Name of Hospital	Dates of Service	Amount
Other	Dates of Service	Amount

_____ _____
(Employer's Signature) **(Employee's Signature)**

_____ _____
(Date) **(Date)**

This form can be returned to DOL with or without employer's signature.

NOTICE TO EMPLOYER

YOU MUST FILE AN EMPLOYER'S FIRST REPORT, Form No. 8WC, WITH THE LABOR COMMISSIONER AND THE NEAREST CLAIMS OFFICE OF YOUR INSURANCE CARRIER, AS SOON AS POSSIBLE AFTER ACQUIRJNG KNOWLEDGE OF THE OCCURRENCE OF AN OCCUPATIONAL INJURY OR DISEASE TO ONE OF YOUR EMPLOYEES OR UPON PRESENTATION OF THIS NOTICE BY HIM, BUT NO LATER THAN FIVE DAYS THEREAFTER. FAILURE TO COMPLY CARRIES AN AUTOMATIC CIVIL PENALTY OF UP TO $2500. (RSA 281-A:53)

New Hampshire

Employer's First Report of Injury

WEB-BWC-
NHDOL#-

Submission Date:

EMPLOYEE INFORMATION

Employee Name (First & Last)	Gender	Hired Date	Hired in NH

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 offojLUy	
Nature of Injury	Witness Name	Witness Phone

Has injured returned to work?	If so, what date?	If so, at what occupation?	If so, at what duty status?

Initial Treatment

Initial Treatment Comments

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 Provider		
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