



NOTICE: WISCONSIN WORKERS COMPENSATION

This business operates under Wisconsin Workers Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

Workers Compensation insurance benefits are provided through:

BerkleyNet

To report a claim, contact us at:

Website: berkleynet.com

Email: claimops@berkleynet.com

Address: 9301 Innovation Drive, Suite 200, Manassas, VA 20110

Phone: 877.497.2637

Fax: 866.275.6320

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development
Worker's Compensation Division
 201 E. Washington Ave., Rm. C100
 P.O. Box 7901
 Madison, WI 53707-7901
 Imaging Server Fax: (608) 260-2503
 Telephone: (608) 266-1340
<http://www.dwd.wisconsin.gov/wc>
 e-mail: DWDDWC@dwd.wisconsin.gov

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
 (Please read the instructions on page 2 for completing this form)

EMPLOYEE	Employee Name (First, Middle, Last)		Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Employee Home Telephone No. () -				
	Employee Street Address			City		State		Zip Code -			
	Birthdate		Date of Hire		County and State Where Accident or Exposure Occurred?						
EMPLOYER	Employer Name		WI Unemployment Ins. Acct No.		Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Nature of Business (Specific Product)				
	Employer Mailing Address			City		State		Zip Code -		Employer FEIN -	
	Name of Worker's Compensation Insurance Co. or Self-Insured Employer								Insurer FEIN -		
Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer								TPA FEIN -			
WAGE INFORMATION	Wage at Time of Injury \$		Specify per hr., wk., mo., yr., etc. Per:		In Addition to Wages, Check Box(es) if Employee Received:		<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Tips		No. of Meals/wk. No. of Days/wk. Avg. Weekly Amt. \$		
	Is Worker Paid for Overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, After How Many Hours of Work Per Week?										
	For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.										
	No. of Weeks:		Gross Amount Excluding Tips: \$			If Piece-Work, No. of Hrs. Excluding Overtime:					
	Employee's Usual Work Schedule When Injured:			Start Time : <input type="checkbox"/> AM <input type="checkbox"/> PM		Hours Per Day		Hours Per Week		Days Per Week	
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:											
INJURY INFORMATION	Part-Time Employment Information:		Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?				Number of Full-Time Employees Doing The Same Type Of Work:				
	Injury Date		Time of Injury : AM : PM		Last Day Worked		Date Employer Notified		<input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		
	Did Injury Cause Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Death		Was This a Lost Time or Other Compensable Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did Injury Occur Because of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Failure to Use Safety Devices <input type="checkbox"/> Failure to Obey Rules				
	Was Employee Treated in an Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No Was Employee Hospitalized Overnight as an In-Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No										
	Name and Address of Treating Practitioner and Hospital: Case Number from the OSHA Log:										
Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.											
What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)											
What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)											
Report Prepared By			Work Phone Number () -		Position			Date Signed			

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

WAGE INFORMATION SUPPLEMENT

Department of Workforce Development
Worker's Compensation Division
 201 E. Washington Ave., Rm. C100
 P.O. Box 7901
 Madison, WI 53707-7901
 Imaging Server Fax: (608) 260-2503
 Telephone: (608) 266-1340
 Fax: (608) 267-0394
 http://www.dwd.wisconsin/wc
 e-mail: DWDDWC@dwd.wisconsin.gov

Insurers, including self-insured employers, must submit this form with the first **WKC-13 report** for each claim where TTD is less than the maximum rate in the year the injury occurred.

Read instructions on reverse carefully before completing.

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
 Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

Employee Name	Employee Social Security Number	Date of Injury
Employer Name		
Name of Insurance Company or Self-Insured Employer (do not list adjusting company)		
Claims Handling Address (number, city, state, zip code)		

Complete Section 4 for part-time employees (include anyone working less than 35 hours per week) before completing Sections 1 and 2.)

1. Hourly Wage Multiply

a. Hourly rate at time of injury: <input type="checkbox"/> Standard Base \$ _____ <input type="checkbox"/> Piece Rate (if higher than the standard rate) <input type="checkbox"/> Standard base rate plus tips Tip Rate only: \$ _____ Base + Tip \$ _____	x	b. Hours per week: (fill in "usual scheduled hours," check the box you use to set the wages) <input type="checkbox"/> Normal scheduled hours: _____ Includes those hours paid at time-and-a-half: (See Instructions) _____ <input type="checkbox"/> Actually Worked: (use with piece rate, or tips in Section 1a.) _____ <input type="checkbox"/> Expand to: (See Section 4) _____ 24 <input type="checkbox"/> Expand to Normal Full-time: _____ <input type="checkbox"/> Seasonal: (See instructions) _____ 44	=	Equals	Add	=	Equals	c. Base weekly rate: (See reverse for computing rates for time and a half employees) \$ _____	+	d. Additional weekly compensation from Section 3 below: (exclude tips) \$ _____	=	e. Average weekly earnings: (hourly) \$ _____
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2. Gross Wage Divide

a. Gross taxable wages in 52-week period prior to date of injury: (Exclude tips) \$ _____	÷	b. Number of weeks worked in 52-week period prior to injury: _____	=	Equals	Add	=	Equals	c. Base Gross Wage: \$ _____	+	d. Additional weekly compensation from Section 3 below: \$ _____	=	e. Actual average weekly earnings: \$ _____
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3. Additions to Cash Wage Received by Employee Per Week (Mark any that apply)

<input type="checkbox"/> Free meals (Number/week) _____ Weekly Amount \$ _____ <input type="checkbox"/> Room (Number of days/wk) _____ Weekly Amount \$ _____ <input type="checkbox"/> Tips Amount/Week \$ _____ (Add only to Section 2d., not 1d.) <input type="checkbox"/> House or Apartment Weekly Amt \$ _____ <input type="checkbox"/> Check if this is continued during disability	<input type="checkbox"/> Fuel Weekly Amount \$ _____ <input type="checkbox"/> Lights Weekly Amount \$ _____ <input type="checkbox"/> Other Weekly Amount \$ _____ Total Weekly Value: \$ _____
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4. Part-Time Employment (Worked less than 35 hrs/wk)

Part of Class Determination	1. Normal number of hours scheduled per week: _____	2. Number of other part-time employees doing same work on same schedule: _____	÷	3. Number of full-time employees doing the same type of work: _____	=	4. <input type="checkbox"/> Yes, part of class (2 divided by 3 is greater than 10%) <input type="checkbox"/> No, not part of class (2 divided by 3 is less than 10%)
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(Choose a, b or c that applies)

- a Employee worked **less** than 24 hrs/wk, **is part of a class and does not restrict** availability for work. Check the box listed as "expand to" in Section 1b above with number of scheduled hours shown as 24.
- b Employee worked less than 35 hours/wk, but **is not part of a class and does not restrict** availability for work. Check the box in Section 1b listed as "Expand to Normal full-time" and enter the number of hours which full-time employees normally work for the employer in this occupation.
- c Employee works less than 27 hrs/wk., **and restricts availability** for work. Check the box in Section 1b listed as "Normal Scheduled Hours" and enter the number of normal scheduled hours. If the employee does not have "normal scheduled hours", leave Section 1b blank and complete all parts of Sections 2 and 5 using the 100% option of the result in Section 2e in Section 5b. **Attach the self-restriction statement.** See instructions on reverse for an **exception to using 100% in Section 5b.**

Important: These options are the only circumstances for which you will use a number other than the "normal hours scheduled" to compute weekly hourly wages. Use normal hours scheduled or actual hours worked (piece rate, time and 1/2 or tip rate) in Section 1b unless 4a, 4b or 4c applies.

5. Weekly Wage and TTD Rate Computation

a. Weekly Wage (Greater of #1 or #2 above) \$ _____	x	b. <input type="checkbox"/> 66.67% OR <input type="checkbox"/> 100%(see 4.c)	=	c. Weekly TTD Rate: \$ _____
Insurance Claim Representative		Telephone Number ()		

Instructions for Completing the Wage Information Supplement, Form WKC-13-A

These instructions will help you complete the WKC-13-A and compute the TTD rate correctly. If more help is needed, please contact a wage specialist at (608) 266-3264 or 261-6532, or send an e-mail to wcwage@dwd.state.wi.us. Section DWD 80.02(2)(c) of the Wis. Admin. Code requires insurers, including self-insured employers, to submit this form within 30 days after the injury. It must be submitted for every claim where the TTD rate is less than the maximum rate for the year the injury occurred. For a reference to the maximum rates, see our website at: http://www.dwd.state.wi.us/wc_train

Section 1a- Hourly Rate at Time of Injury: Enter the standard base rate at the time of injury. Include in the hourly rate any additional hourly amounts which the employee received at the time of injury, e.g., shift differentials. For employees receiving time-and-a-half, enter the standard base rate, not time and a half rate. If this employee did not have an hourly rate but had a weekly, bi-weekly or monthly salary and has scheduled hours of work, divide the salary by the number of hours worked in the pay period to arrive at the hourly rate. If an employee is paid solely by commission or by mileage or some other method where scheduled hours are not used, the TTD rate will be based only on gross earnings. In such a case, enter "NA" in Section 1 and go on to Section 2. For employees paid on a piece work basis, compute the hourly piece work rate by dividing the earnings from piece work by the number of hours actually worked while on piece rate. Exclude time and a half earnings and hours in this computation. Use the piece rate amount only if the resulting rate is higher than the standard hourly rate. If the employee received tips, compute the additional hourly amount of tips. Enter that amount next to "tip rate" and add the hourly tip rate to the standard hourly rate to get the "standard base rate plus tips". Compute the tip rate by dividing total tip earnings (only the earnings received in tips) by total hours actually worked on a tip basis. The total hourly rate must be at least the legal minimum hourly wage.

Section 1b- Hours Per Week: Enter the normal number of hours scheduled (regular fixed schedule) at the time of injury). Include the number of hours the employee is paid at the time and a half rate. If the employee does not have regular scheduled hours, enter the number of hours which full-time employees normally work for the employer in this occupation. Include scheduled hours paid at a time-and-a-half rate in the number of "normally scheduled hours". If scheduled hours vary by more than 5 hours from week to week during the 90-day period immediately preceding the injury, use the number of hours that is normal for full time employees for this occupation. Check the box "Actually Worked" in Section 1b and enter the hours actually worked if the hourly rate in Section 1a is piece rate or includes tips. Check the "seasonal" box with 44 hours entered for employees who meet the definition of "seasonal" employees in s.102.11(1)(b) Wis. Stats. Seasonal employment cannot exceed 14 weeks. For part time employees, follow the instructions in Section 4.

Section 1c- Base Weekly Rate: Multiply the hourly rate in Section 1a times the hours used in Section 1b. For employees who worked a time and a half schedule at the time of injury and at least 13 consecutive weeks immediately prior to the injury, use the following formula: multiply the standard rate times the normal scheduled hours excluding those hours paid at the time-and-a-half rate; then multiply the time and a half rate times the time and a half hours, and add the two results to get the Base Weekly Rate.

Sections 1d & 1e- Hourly Wages/Additions to Base Average Weekly Wages and Average Weekly Earnings: Enter here and in Section 2d (except for tips) the weekly value of any other type of compensation the employee received, as shown in Section 3.

Section 2a-e Gross Wages and Average Weekly Earnings Enter the gross wages and the number of weeks the employee worked on that job (same type of work) in the 52-week period prior to the date of injury. When counting weeks for Section 2b, do not include the week of injury in the 52-week period. Count partial weeks as whole weeks. Include tips and additions to wages from Section 3 in section 2e. For employees who worked less than 6 weeks, TTD will be determined solely by the hourly rate in Section 1 or, if the employee does not have an hourly rate, by wages paid in a "same or similar" occupation. Enter "same or similar" wages in Section 2e and skip 2a, 2c and 2d. Complete the computations in Sections 2c, d and e for all others.

Section 3- Additions to Cash Wages: Enter the weekly value of any additional compensation paid to the employee. This value is added to the computations in Sections 1 and 2. The standard value of "meals" and "room" is set in Wis. Admin. Code DWD 80.29 and DWD 272. The value of all other items is set by common marketplace value to the employee.

Section 4- Part-Time Employment: Complete this Section for all workers at less than the maximum TTD rate if they were scheduled to work less than 35 hours per week at the time of injury.

Part of Class Determination: Complete this part before choosing and checking the applicable Section 4a, 4b or 4c. If the employee's regular work schedule varies by more than 5 hours per week during the 90-day period immediately preceding the injury, always consider the employee as "not part of class". Choose Section 4a, 4b or 4c that applies to the employee before doing the computations in Sections 1 or 2 to set the wage for the employee. If you check Section 4b, you will need to check the box in Section 1b "expand to normal full-time" and enter the number of normal full-time hours there for this occupation. Use the number of hours that are normally considered as full-time for that employer for that occupation to compute the wage.

Self Restriction: An employee "self restricts" employment if he/she limits his/her availability on the labor market to part-time work only and was not employed elsewhere. If you indicate that the worker self-restricts in Section 4c and wages are set at 100%, you must attach a copy of a self-restriction statement signed by the employee, stating the limitation to part-time and that he/she was not working elsewhere at the time of injury. A sample statement can be found in the training website at http://www.dwd.state.wi.us/wc_train.

Section 5-- Wage and Rate Computation: Enter the wage used to compute the TTD rate (the higher amount from Section 1e or 2e). The rate in Section 5c is computed by multiplying the wage by either 66.67% or by 100% (see Section 4c).

Exception to using 100% in Sections 4c and 5b: If using 100% in Section 4c exceeds 66.67% of the wages of a full-time employee doing this job, use 66.67% of wages (higher of 1e or 2e) after expanding the hours in Section 1b to full-time.

Exception Note: If this employee's employment situation is unique and you cannot use the computation formulas in Sections 1 and 2, indicate the wage and TTD rate in Section 5, and attach an explanation of how you computed the wage and TTD rate to this request.

Voluntary and Informed Consent for Disclosure of Health Care Information

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

**Department of Workforce Development
Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
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<http://dwd.wisconsin.gov/wc/>
e-mail: DWDDWC@dwd.wisconsin.gov

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name		Street Address	
P. O. Box	City	State	Zip Code
Patient (Employee) Name		Employer Name	
Patient Social Security Number - -	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

CHECK ONE:

- A. Physical Only.** Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

- B. Physical and Other.** Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B

Patient Signature (or Person Authorized to Sign for Patient)	Date
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In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient)	Date
If not signed by patient, authority/designation to sign is based on the fact that the patient is <input type="checkbox"/> A minor <input type="checkbox"/> Incompetent <input type="checkbox"/> Disabled <input type="checkbox"/> Deceased <input type="checkbox"/> Other:	