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EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

An employer shall report immediately to the agency on Form WC-100 all injuries, including diseases, which arise out of and in the course of the employment, or on which a claim is made and result in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific losses. In case of death, an employer shall also immediately file an additional report on WC-106. See instructions on reverse side for filing/mailing procedures.

I. EMPLOYEE DATA

1. Social Security Number	2. Date of injury	3. Employee name (Last, First, MI)		
4. Address (Number & Street)		5. City	6. State	7. ZIP Code
8. Date of birth (MM/DD/YYYY)	9. Sex ☐ Male ☐ Female	10. Number of dependents	11. Telephone number	
12. Tax filing status: ☐ A. Single ☐ B. Single, Head of Household ☐ C. Married, Filing Joint ☐ D. Married, Filing Separate				

II. EMPLOYER/CARRIER DATA

13. Employer name			14. Federal ID Number	
Consolidated Electrical Contractors			27-0864676	
15. Injury location code	16. Mailing location code	17. UI number	18. Type of business (SIC/NAICS)	
			1731	
19. Employer street address		20. City	21. State	22. ZIP code
1095a Mak-Tech Dr		Lansing	MI	48906
23. Insurance company name (if employer not self-insured)			24. Insurance company telephone number (if known)	
Comprehensive Risk Services			800-737-9875	

III. INJURY/MEDICAL DATA

25. Last day worked	26. Date employee returned to work (if applicable)		27. Did employee die? ☐ Yes ☐ No	28. If yes, date of death
29. Injury city	30. Injury state	31. Injury county	32. Did injury occur on employer's premises? ☐ Yes ☐ No (If no, see item 53)	
33. Case number from OSHA/MIOSHA log	34. Time employee began work ☐ a.m. ☐ p.m.		35. Time of event ☐ a.m. ☐ p.m.	If time cannot be determined, check here ☐

36. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific.

37. How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet;" "Worker was sprayed with chlorine when gasket broke during replacement"

38. Describe the nature of injury or illness	39. Part of body directly affected by the injury or illness

40. What object or substance directly harmed the employee? Examples: concrete floor, chlorine, radial arm saw. If this question does not apply to the incident, leave it blank.

41. Name of physician or other health care professional	42. Was employee treated in an emergency room? ☐ Yes ☐ No	43. Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

44. If treatment was given away from the worksite, where was it given? (Include name, address, city, state and ZIP code of facility)

IV. OCCUPATION AND WAGE DATA

45. Date hired	46. Total gross weekly wage (highest 39 of 52)	47. Number of weeks used	48. Value of discontinued fringes
49. Occupation (Be specific)	50. Was employee a volunteer worker? ☐ Yes ☐ No	51. Was employee certified as vocationally handicapped? ☐ Yes ☐ No	
52. Date employer notified by employee	53. If temporary service agency, provide name/address of employer where injury occurred.		

V. PREPARER DATA

I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

54. Preparer's name (Please print or type)	55. Preparer's signature	56. Telephone number	57. Date prepared

Notice to employee: Questions or errors should be reported immediately to the individual listed above in space 54