LAB 500

New Hampshire

Employer's First Report of Injury

Submission Date: _____

WEB-8WC –

NHDOL# -

EMPLOYEE INFORMATION					
Employee Name (First & Last)		Gender	Hired Date		Hired in NH
ID Type - 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 of Injury	
Nature of Injury	Witness Name	Witness Phone

Returned to work?	If so, what date?	If so, at what occupation?	If so, at what duty status?

Initial Treatment	Initial Treatment Date

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 Organization		
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

LAB 500

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

NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE 8aWCA

(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 ACQUIRING 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)