

**EMPLOYER'S BASIC REPORT OF INJURY**  
Michigan Department of Energy, Labor & Economic Growth  
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/mailling 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		10. Number of dependents		11. Telephone number
12. Tax filing status: <input type="checkbox"/> A. Single <input type="checkbox"/> B. Single, Head of Household <input type="checkbox"/> C. Married, Filing Joint <input type="checkbox"/> D. Married, Filing Separate						

**II. EMPLOYER/CARRIER DATA**

13. Employer name			14. Federal ID Number			
15. Injury location code		16. Mailing location code		17. UI number		18. Type of business (SIC/NAICS)
19. Employer street address			20. City		21. State	22. ZIP code
23. Insurance company name (if employer not self-insured)				24. Insurance company telephone number (if known)		

**III. INJURY/MEDICAL DATA**

25. Last day worked		26. Date employee returned to work (if applicable)		27. Did employee die? <input type="checkbox"/> Yes <input type="checkbox"/> No		28. If yes, date of death
29. Injury city		30. Injury state	31. Injury county		32. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, see item 53)	
33. Case number from OSHA/MIOSHA log			34. Time employee began work <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		35. Time of event <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. If time cannot be determined, check here <input type="checkbox"/>	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		43. Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		51. Was employee certified as vocationally handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> 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

<b><i>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.</i></b>						
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**

If you are using this form as a replacement for the Form 301 to document the specifics of an injury or illness for purposes of compliance with the work-related injury and illness logging requirements, follow the instructions in Section A only.

If you are using this form to report a workers' compensation injury, follow the instructions in Section A and B.

## Section A

This form can be used in lieu of the MIOSHA Form 301, *Injury and Illness Incident Report*. It is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* (Form 300) and the accompanying *Summary* (Form 300A), these forms help the employer and MIOSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out questions 1-9, 27-28, 33-45 and 54-57.

According to Public Law of 1970 (P.L. 91-596) and Michigan Occupational Safety and Health Act 154, P.A. 1974, Part 11, Michigan Administrative Rule for Recording and Reporting of Injuries and Illnesses, you must keep this form on file for 5 years following the year to which it pertains. **DO NOT mail this form to the Workers' Compensation Agency unless it meets the conditions listed below in Section B.**

---

## Section B

You must complete all questions on this form if the injury or disease results in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific loss. The original form must be mailed to the Workers' Compensation Agency, P.O. Box 30016, Lansing, MI 48909.

Authority: Workers' Disability Compensation Act, 408.31(1)(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631	DELEG is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.
--	---