FOR DIVISION USE ONLY

Report of Occupational Injury

Return Completed Form To:

West Virginia Workers' Compensation Division
P.O. Box 3151
Charleston, WV 25332

• SECTION I - TO BE COMPLETED BY THE INJURED WORKER (please print with ballpoint pen or type.) ALL BLOCKS MUST BE COMPLETED.

1. Claimant's Full Name					2. Claimant's Social Security Number
3. Claimant's Complete Mailing Address Street or P 0 Box City State Zip Code					4. Date and Time of Injury ☐ AM ☐ PM
5 Claimant's Telephone No.	6. Date of Birth	7. ☐ Male ☐ Female	8. Marital Status	9. County In Which You Live	10. Job Title
11. Name and Address of Company for Whom You Work	12. Did Injury Occur on Employer's Property? ☐ Yes ☐ No If No, Where?		13. If You Worked for Present Employer Less Than One Year, List Prior Employer(s).		**FOR DIVISION USE ONLY** **ICD9-CM** _____ **County** _____
14. Time You Began Work on the Day Injury Occurred ☐ AM ☐ PM	15. Date and Time You Stopped Work Due to this Injury. ☐ AM ☐ PM		16. Date You First Went to Doctor/Hospital	17. Name and Address of Doctor/Hospital Where You Were First Treated for this Injury.	**Occupation** _____ **Nature** _____ **Body** _____
18. List Name(s) of witness(es) if Any, to the Accident	19. Have You Ever Had Any Previous Accidents or Conditions Affecting Part Body Affected by this Injury? ☐ Yes ☐ No If Yes, Give Date(s) Details of the Injuries/Conditions.				**Type** _____ **Source** _____ **Agent** _____
20. Describe Exact Nature of Injury and Specific Part(s) of Body Affected, (Specify Right or Left if Applicable.)	21. How Did Injury Occur? (Specify the cause, what you were doing, and equipment/objects involved.)			22. What Was Your Average Rate of Pay(Gross) on the Date of Injury? _____ What is the average number of hours you work per week? _____ hours 23. State and County Where Accident Occurred	

24. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit to which I am not entitled. By signing this application, I authorize the West Virginia Workers' Compensation Division to examine medical records and have verbal discussions with physicians, on any medical information pertaining to this injury and any condition for which I have previously received medical attention; and, I acknowledge the provisions of Code 23-4-7 providing authorization for release of medical information by a physician to my employer or employer representative.

Claimant's Signature _____ Date _____

• SECTION 11 TO BE COMPLETED BY THE ATTENDING PHYSICIAN (Please print with ballpoint pen or type.) ALL BLOCKS MUST BE COMPLETED.

1. Physician's Name and Address	2. Physician's Telephone No. 3. Physician's FEIN or Social Security No.	4. Is Condition Result of: Occupational Injury ☐ Yes ☐ No Occupational Disease ☐ Yes ☐ No Nonoccupational Condition ☐ Yes ☐ No
5. Diagnosis Code(s) (ICD9-CM) in Order of Severity	6. Description of Injury (fracture, burn, etc.) and Part(s) of Body Injured/Affected	
7. Date You Were First Consulted for this Condition 8. Date Claimant Stopped Work Due to this Condition	9. List Claimant's Complaints and How they Affect the Ability to Work. 10. Will Claimant Need Physical or Vocational Rehabilitation Services? ☐ Yes ☐ No	11. Does Claimant Have a Chronic or Prior Injury/Disease Which Was Aggravated by this injury and Which May Delay Recovery from this Injury? ☐ Yes ☐ No If Yes, Please Explain:
12. Estimated Period of Temporary Total Disability (Do not answer undetermined or unknown.) ☐ Less than 4 days ☐ 2 Weeks ☐ 3 Weeks ☐ 1 Week ☐ 4 Weeks or More	13. Have You Referred Claimant to Another Physician? ☐ Yes ☐ No If Yes, Give Name & Address of Physician.	14. Was Claimant Hospitalized Due to this Injury? ☐ Yes ☐ No If Yes, Give Name and Address of Hospital
15. Were any Office Notes Made or Diagnostic Studies Carried Out in Relation of the Current Incident? ☐ Yes ☐ No If Yes, Please Forward a Copy to Workers' Compensation as Soon as Possible.	16. Date Claimant Was (Will Be) Able to Return to Full-time Work 17. Is Claimant Able to Return to Modified Work? ☐ Yes ☐ No	18. In Your Opinion, Is the Current Period of Disability a Direct Result of the Injury/Disease Described by the Claimant? ☐ Yes ☐ No If No, Please explain:

19. Under penalty of perjury, I certify that the information provided in Section II is, to the best of my knowledge, true and correct.

Physician's Written Signature _____ Date _____

Employer sign here as acknowledgement of receipt of Sections I and II _____ **Date** _____

• SECTION III - TO BE COMPLETED BY THE EMPLOYER (Please print with ballpoint pen or type.) ALL BLOCKS MUST BE COMPLETED.

1. Employer's Name, Address & Telephone No.	2. Name and Address of Operation Where Accident Occurred	3. County Where Accident Occurred 4. Employer's FEIN or Social Security No.	5. _____ Fisk Number _____ Class Number
6. What Was the Gross Average Daily Rate of Pay on the Date of Injury _____ If Part-time Employee, Give Hourly Wage and Average Number of Hours Worked. Hourly Rate: _____ Average No. of Hours Per Week: _____		7. Do You Disagree With Any of the Information Provided in Section I or II, or Do You Have Any Reason to Question this Injury? ☐ Yes ☐ No If Yes, You Must Attach a Specific Explanation.	
8. Date Employee Was First Employed By You Amount of Time in Present Job _____ Occupation (DOT) Code _____		9. Is Claimant an Owner, Part Owner, or Officer of the Business? ☐ Yes ☐ No If Yes, Do You Include His/Her Wages on Your Quarterly Report ☐ Yes ☐ No	10. Date Claimant Returned to Work

I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly certify a false report or statement respecting any information requested by the Commissioner.

Employer's Written Signature _____ Title _____ Date _____

General Instructions For Completing Form WC- 1 23
REPORT OF OCCUPATIONAL INJURY

The Report of Occupational Injury, form WC-1 23, is divided into three sections which must be completed by the injured worker, the treating physician, and the employer. It is very important that all three parties complete the form correctly as the information on this form is the basis upon which benefits are paid or denied. Benefits may be delayed if incorrect or incomplete information is given.

It is the responsibility of the injured worker to complete Section I of this form and have the attending physician complete Section II. After Sections I and II have been completed, the gold copy of the form should be kept by the doctor or hospital and the remaining copies returned to the injured worker. The pink copy of the form should be kept by the injured worker when the form is given to the employer for completion of Section III. The employer is responsible for sending the form to the Workers' Compensation Division after completing Section III.

INJURED WORKER: If you do not receive a decision on your claim within 14 days after the form was given to your employer, you should contact the Workers' compensation Division.

EMPLOYER: The gross average daily rate of pay of the injured employee on the date of the injury, as requested in Section III - question #6, is determined by dividing the employee's gross pay for the past three months (90 days), by the number of days worked by the employee for that period. Please be sure to add any overtime pay earned during the three-month period to the gross pay for that period when calculating the gross average daily rate of pay.

All parties completing this form may attach a separate sheet if additional space is needed.