SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

Housing Authority of the
City of Milwaukee
Form EB-49-10/2005

REPORT OF ACCIDENT TO EMPLOYE
UNDER WORKER'S COMPENSATION ACT

DEPARTMENT REGULARLY WORKED IN	EMPLOYEE HEALTH PLAN	IS THIS EMPLOYE ELIGIBLE FOR INJURY PAY? ☐ YES ☐ NO
		HOW IS EMPLOYE BEING PAID? INJURY ☐ SICK ☐ NO-PAY ☐

Name of Witnesses

The provision of your social security number 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)]. See instructions for completing this form on reverse side.

EMPLOYE

Employee Name (First, Middle, Last)	Social Security Number	Sex ☐M ☐F	Employee Home Telephone No.

Employee Street Address	City	State	Zip Code	Occupation

Birthdate Mo. Day Year	Date of Hire	County and State where accident or exposure occurred.

EMPLOYER

Employer Name	WI Unemployment Insurance Account No.	Self-Insured? ☐ Yes ☐ 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:	☐ Meals ☐ Room ☐ Tips	No. of Meals/wk. ____ No. of Days/wk. ____ Av. Weekly Amt. $____

Is worker paid for overtime? ☐ Yes ☐ No If yes, after how many hours of work per week?

For the 52 week period prior to the date 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

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	☐ AM ☐ PM			
Employer's Usual Full-Time Schedule For This Type of Work At Time of Employee's Injury:				

Part-Time Employment Information	Are there other part-time workers doing the same work with the same schedule? ☐ Yes ☐ No If yes, how many?	Number of full-time employees doing the same type of work.

INJURY INFORMATION

Injury Date	Time of Injury AM PM	Last Day Worked	Date Employer Notified	☐ Date Returned to Work ☐ Estimated Date of Return

Did injury cause death? ☐ Yes ☐ No	*Date of Death*	Was this a lost time or other compensable injury? ☐ *Yes* ☐ No	Did injury occur because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was employee treated in emergency room? ☐ Yes ☐ No Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Name and Complete Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe activities of the employee when the injury or illness occurred and what tools, machinery, objects, chemicals, etc. that 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 the body affected and how it was affected)

Report Prepared By:	Work Phone	Position:	Date Signed:

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wkc-12 (Rev.03/2002) *White - Employee Benefits Division / Pink - Director of Safety / Yellow - Department / Blue - Bureau or Division*

HOUSING AUTHORITY OF THE CITY OF MILWAUKEE
STATEMENT OF EMPLOYEE INJURED

Employee Name	Date
Department/Section	
Date of Injury	
Place of Injury	
Explain how the injury happened:	
Employee Signature	Date

HOUSING AUTHORITY OF THE CITY OF MILWAUKEE
STATEMENT OF WITNESS TO INJURY

Name of Witness
Department
Name of Injured Employee
Date of Injury
Description of how Employee was injured:

Signature of Witness	Date

HOUSING AUTHORITY OF THE CITY OF MILWAUKEE
SUPERVISOR'S ACCIDENT REPORT

Name of Injured Employee
Department/Section
Date of Injury
My investigation of this incident reveals the following:
Unsafe act by injured and/or other contributing to the incident:
Unsafe condition of equipment, materials or environment:
Estimated number of days away from job:
The basic cause of this accident in my opinion was:
What action has been taken to prevent similar incidents in the future?
I investigated this accident on this date:
Supervisor's Signature
Supervisor's Telephone Number: