MAIL TO:
WORKERS' COMPENSATION INSURER

023-52-2914
Employee Social Security Number
WCLA5341KCV0012
Employer UI Account Number
02-0788384
Employer Federal ID Number

EMPLOYER REPORT
OF
INJURY/ILLNESS

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately.

PURPOSE OF REPORT: (Check all that apply)

- [x] More than 7 days of disability
- [ ] Injury resulted in death
- [ ] Amputation or disfigurement
- [ ] Possible dispute
- [ ] Lump Sum Compromise/Settlement
- [ ] Other
- [ ] Medical only (**DO NOT mail copy to OWCA**)

1. Date of Report MM/DD/YY	2. Date / time of Injury MM/DD/YY Time	3. Normal Starting Time Day of Accident	4. If Back to Work - Give date MM/DD/YY	5. At same wage?	DO NOT WRITE IN THIS COLUMN
11/13/12	11/13/12 11:20 [x] PM [ ] PM	6:00 [x] AM [ ] PM		[ ] Yes [ ] No	

6. If Fatal Injury, Give Date of Death MM/DD/YY	7. Date Employer Knew of Injury MM/DD/YY	8. Date Disability began MM/DD/YY	9. Last Full Day Paid MM/DD/YY	Date Received
	11/13/12	11/13/12	11/12/12	

10. Employee Name First / Middle / Last	11. [x] Male [ ] Female	12. Employee Phone #	Naics:
Kenneth Adams		(985) 960-0137	

13. Address and Zip Code	14. Parish of Injury	State-Parish
316 Dorcy Lane Slidell LA 70460	St. Tammany	

15. Date of Hire	16. Date of Birth	17. Occupation	18. Dept/Division Employed	Occupation
01/17/11		Electrical		

19. Place of Injury-Employer's Premises? [ ] Yes [x] No	20. If No, Indicate Location-Street, City, Parish and State	Nature
	Front Street Slidell St. Tammany Louisiana	

21. What work activity was the employee doing when the injury occurred? (Give weight, size and shape of materials or equipment involved). Explain what employee was doing with them. Indicate if correct procedures were followed.
CLIMBING SCAFFOLD TO MOVE LIGHT

Part of Body | Source | Event | NCCI

22. What caused injury to happen? (Describe fully the events which resulted in injury or disease. Explain what happened and how it happened. Name any objects or substances involved and explain how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)
SLIPPED AND FELL

23. Part of Body Injured and Nature of Injury or Illness (ex. left leg; multiple fractures)	24. If Occ. Disease-Give Date Diagnosed
Head, Wrist, Ribs, possibly Hip	

25. Physician and Address	26. If Hospitalized, give name & address of facility
Slidell Memorial Hospital	Slidell Memorial Hospital
27. Employer's Name: Gulf Coast Electric Co., LLC	28. Person Completing This Report - Please print
29. Employer's Address and Zip Code: 554 Old Spanish Trail Slidell, LA 70458	30. Employer's Telephone Number: 985-649-5832
31. Employer's Mailing Address-If Different From Above	32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.: Electrical

33. Wage Information (optional) Employee was paid [ ] Daily [x] Weekly [ ] Monthly [ ] Other. The average weekly wage was $_____ per week.

LDOL-WC-1007
Rev: 08/06

Insurer Name:
Phone:
Address:

Insurer's Administrator or Representative:
Phone:
Address:

Download Employer's Certificate of Compliance