Form OIC-WC-2

West Virginia Workers' Compensation
Employers' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I — Employer Information

Insurer: BrickStreet Insurance | **Third-Party Administrator:** Encova Insurance

Employer's Name: WV MILITARY AUTHORITY | Nature of Business: | FEIN: 55-6000748

Address: 1703 COONSKIN DRIVE

City: CHARLESTON | State: WV | Zip: 25311 | Telephone: (304) 561-6747

Section II — Employee Information

Name: (Last): (First): (M.I.):

Address:

City: State: Zip:

Date of Birth: ____/____/____ **6. Sex:** ☐ M ☐ F

Injured Employee is (check all that apply): ☐ Full-Time ☐ Part-Time ☐ Volunteer ☐ Owner/Partner ☐ Officer ☐ Retired – Date Retired: ____/____/____

Occupation/Job Title:

Telephone: ( )

Social Security No.:

Marital Status:

Employee's Occupation/Job Title:

Section III — Information Regarding Injury or Disease

Date of Injury or Last Exposure: ____/____/____ **Time:** ☐ a.m. ☐ p.m.

Date Employer Notified of Injury or Disease:

Supervisor to whom Injury or Disease Reported:

If Injury was Fatal, Indicate Date of Death: ____/____/____

Did Injury Occur on Employer's Property? ☐ Yes ☐ No Address or location where injury occurred:

Witnesses to Injury:

What was the Employee Doing when Injury Occurred (loading truck, walking down stairs, etc.)**:**

How did the Injury or Disease Occur (be specific; include time that employee began work on the date of injury, any equipment, tools, substances or objects connected to the injury; attach additional sheet if necessary)**:**

Nature of Injury or Disease (cut, bruise, strain, etc.):

Body Part(s) Injured:

Are You Aware of, or Do You Suspect, a Prior Injury to this Body Part? ☐ Yes ☐ No

Do You Have Reason to Question this Injury? ☐ Yes ☐ No (If "yes," attach a specific explanation to this form).

Location of Initial Treatment: **Emergency Room?** ☐ Yes ☐ No **Hospitalized?** ☐ Yes ☐ No

Section IV — Wage and Lost Time Information

Date Hired: ____/____/____

Last Day Worked After Occupational Injury or Disease: ____/____/____

Number of Work Days Lost:

Date of Return to Work: ____/____/____

Hours Worked per Week:

Is Light Duty Available? ☐ Yes ☐ No

Wage on Date of Injury: $ per ☐ hour ☐ day ☐ week ☐ month

Are Wages Being Paid to Injured Employee During Disability? ☐ Yes ☐ No

If Employee has Returned to Work, is it Alternative or Modified Work? ☐ Yes ☐ No

If "yes," indicate current wage: **$** per ☐ hour ☐ day ☐ week ☐ month

Daily rate of pay on the date of injury: $ **and best quarter wages of preceding four quarters** $

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically West Virginia Code §61-3-24e, provides for severe penalties if I knowingly certify a false report or statement and/or withhold a material fact regarding any information requested. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.

Print Name: _____ **Title:** _____

Signature: _____ **Date:** _____/_____/_____