EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P.O. Box 30016 Lansing, MI 48909

AN EMPLOYER SHALL REPORT IMMEDIATELLY TO THE BUREAU ON FORM BWC-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 BWC-106.

I. EMPLOYEE DATA

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	
4. Street Address	5. City	6. State	7. Zip Code
8. Date of Birth	9. Sex ( ) Male ( ) Female	10. Number of Independents	11. Telephone Number
12. Tax Filing Status ( ) A. Single ( ) B. Single, Head of Household ( ) C. Married, Filing Joint ( ) D. Married, Filing Separate			

I. EMPLOYER/CARRIER DATA

13. Employer Name		14. Federal ID Number	
15. Injury Location Code	16. Mailing Location Code	17. MESC Number	19. Type of Business
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)	
25. Second Employer Name (If applicable)		26. Second Employer Average Weekly Wage	

II. ALLEGED INJURY DATA

27. Last Day Worked	28. Date Employee Returned to Work	29. Did Employee Die? ( ) Yes ( ) No	
30. Injury City	31. Injury State	32. Injury County	33. Did Injury Occur on Employer's Premises? ( ) Yes ( ) No* (*If no, see item 46)
34. Describe the Nature of Injury or Illness			
35. Part of Body Directly Affected by the Injury or Illness (Example: Hand, Arm, Circulatory System)			
36. Describe the Events Which Caused the Injury (Example: Fell, Operating Machinery, Chemical Exposure)			
37. Name the object or Substance Which Directly Injured the Employee (Example: Knife, Acid, Floor, Oil)			

III. OCCUPATION AND WAGE DATA

38. Date Hired	39. Total Gross Weekly Wage (Highest 39 of 52)	40. Number of Weeks Used	41. Value Discontinued Fringes $
42. Occupation (Be Specific)	43. Was Employee a Volunteer Worker ( ) Yes ( ) No	45. Was Employee Certified as Vocationally Handicapped? ( ) Yes ( ) No	
45. Date Employer Notified by Employee		46. 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

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.	Authority: Workers' Disability Compensation Act, R408.31(1)(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631

47. Preparer's Name (Please Print	48. Preparer's Signature	49. Telephone Number	50. Date Prepared

NOTICE TO EMPLOYEE: Questions or errors should be reported immediately to the individual listed above in line 47.

BWC-100 (Rev. 10/96) Formerly MDL-1-100.