STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DOA-6058 (R05/2007)
S. 102.37, WIS. STATS

Employee Workplace Injury or Illness Report

BUREAU OF STATE RISK MANAGEMENT
DIVISION OF ENTERPRISE OPERATIONS

WC CLAIM NUMBER

Employee's Instructions (Direct any questions to your Agency's Worker's Compensation Coordinator)
Notify your Supervisor and/or Agency's Worker's Compensation Coordinator immediately in case of an occurrence.
Sign and date the completed report and submit to your Supervisor within 24 hours of the occurrence.

Employee Name (as it appears on payroll)	Employee Job Title:	Social Security Number

Date of Occurrence (mm/dd/ccyy):	Time of Occurrence ☐AM ☐PM	Date Occurrence was reported to employer (mm/dd/ccyy):

Home Address:	Street Address of Current Work Facility	Home Telephone ( ) -	Work Telephone ( ) -

How long have you been in this job title?	Job title before this one?

What happened to cause the present occurrence? (Please be specific. Include contributing factors such as weather, equipment problems, etc.)

Where did the occurrence happen? (Please be specific: Inside or outside, include building name, room, vehicle, etc.)

Were there any witnesses to the occurrence? ☐ Yes ☐ No Please provide names.

Did the occurrence involve one of the following? **Check the most appropriate box.**

- ☐ Restraining
- ☐ Repetitive task
- ☐ Lifting
- ☐ Pushing
- ☐ Pulling
- ☐ Moving
- ☐ Twisting/Pivoting
- ☐ Crushing
- ☐ Bending
- ☐ Reaching
- ☐ Transferring
- ☐ Carrying
- ☐ Motorized equipment
- ☐ Machinery
- ☐ Caught in, under, between
- ☐ Thrown from _____
- ☐ Slips, trips, falls
- ☐ Struck by _____
- ☐ Vehicle/other transport mode
- ☐ Aggressive contact with person
- ☐ Contusion, laceration, sprain
- ☐ Splash/spit/spill
- ☐ Human/animal bite
- ☐ Burn
- ☐ Needle stick injury
- ☐ Contact with object
- ☐ Unsafe act
- ☐ Allergic reaction/sting
- ☐ Hazardous substances
- ☐ Respiratory condition
- ☐ Other, Specify:

Please indicate the part of the body that was involved.
Check all that apply. (1=Big Toe or Thumb) L = Left R = Right

Leg	☐L	☐R	Arm	☐L	☐R	Shoulder	☐L	☐R	☐ Nose	☐ Head	☐ Neck	☐ Mouth			
Knee	☐L	☐R	Elbow	☐L	☐R	Chest	☐L	☐R	Abdomen	☐ Upper	☐ Middle	☐ Lower			
Ankle	☐L	☐R	Wrist	☐L	☐R	Ear	☐L	☐R	Back	☐ Upper	☐ Middle	☐ Lower			
Foot	☐L	☐R	Hand	☐L	☐R	Eye	☐L	☐R	Other, Specify:						
Toe	☐1L	☐2L	☐3L	☐4L	☐5L	☐1R	☐2R	☐3R	☐4R	☐5R	Finger	☐1L	☐2L	☐3L	☐4L	☐5L	☐1R	☐2R	☐3R	☐4R	☐5R

		Name, address, and phone number of Treating Practitioner
Did you seek medical treatment?	☐ Yes ☐ No ☐ Appt. Scheduled	
Will time be lost from work (4 days or more)?	☐ Yes ☐ No ☐ Don't know yet	
Will there be work restrictions?	☐ Yes ☐ No ☐ Don't know yet	
Was first aid provided?	☐ Yes ☐ No	

Do you have a second job? ☐ Yes ☐ No	Name of Employer	Address and phone number of Additional Employer

Have you ever been treated for a similar injury or illness? ☐ Yes ☐ No When? (mm/dd/ccyy)	Name and address of Treating Practitioner /Hospital where similar injury was treated	Phone number of treating practitioner/hospital ( )

I certify that the above statements are true and accurate and I understand that a false worker's compensation claim is a violation of Wisconsin criminal code, which may result in a fine, imprisonment, or termination of employment.

Employee Signature: Date:

Your social security number must be provided for the use of positive identification in the processing of any claims.

To Be Completed By Agency Worker's Compensation Coordinator

Claim Examiner/Representative	Employing State Agency/Unit:	Organization Code	Date:

This document can be made available in alternate formats to persons with disabilities, upon request.