STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DOA-6058 (R07/2017)
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:
Date of Occurrence (mm/dd/ccyy):	Time of Injury: 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? (Be specific. Add 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
- ☐ Resident/Inmate # _____
- ☐ 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 (inc. Area Code)

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:

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.

Guidelines for Completing DOA-6058 Employee's Workplace Injury or Illness Report

Employees Instructions for filling out this report

1. Notify your Supervisor and/or Agency's Worker's Compensation (WC) Coordinator immediately in case of an occurrence.

2. Affected employees seeking Worker's Compensation for workplace injury or illness should fill out this report within 24 hours of injury/illness. Signed and dated reports must be submitted to the supervisor.

3. Please note that all sections in this report must be completed. If any part of the section or question is not applicable to the job or the injury, write 'N/A' (Not Applicable) as a response. Incomplete reports might cause delays in processing of worker's compensation claims.

4. Do not forget to sign and date and put your contact information on the completed document. A WC Coordinator might call you if there is need for more information on the claim.

5. ***Providing inaccurate information and false claims is a violation of s. Admin 943.395, Wisconsin Administration Code, and may result in fine, imprisonment and/or termination of employment.***

Section Instructions

The following information explains the details required in some of the sections in the report and/or its importance in processing WC claims.

Date of occurrence (mm/dd/ccyy): This refers to the date when the injury or illness occurred. In case of cumulative trauma injuries or illnesses, this refers to the date when the symptoms were first experienced.

Date occurrence was reported to employer: This refers to the date that the occurrence was reported to your supervisor or an agency management representative.

Street address of current work facility: This refers to your current employing State agency/unit address.

Job Title before this one: You need to specify your job title, if any, prior to the current one.

What happened to cause the present occurrence?: Specify the chain of events that led to the injury/illness. For example, "There was an overlooked spill due to leakage from the tank. I slipped and fell on the ground and hurt my back."

Where did the occurrence happen? This information is also important for taking measures that can prevent occurrence of similar injuries/illnesses in the future. Specify the exact location where you got injured/ill.

Were there any witnesses? This is an important information from the point of view of processing claims. It helps to speed up the investigation by the Worker's Compensation Coordinator. Specify names of people who witnessed the events that led to the injury/illness.

Did the occurrence involve any of the following: Please check the box that best describes the type, cause or reason for the occurrence.

Please indicate the part of the body that was involved: This refers to the part of the body that was involved in the injury/illness. The numbering of the toes and hands are from one to five. The number one is considered the great toe or thumb and number five considered the little toe or pinkie.

Did you seek medical treatment?: This question asks if you have visited a physician or nurse for your injury/illness. If an appointment is scheduled, check the appropriate box.

Will there be work restrictions?: This question asks if you will have to perform light duty tasks due to physical restrictions imposed by the injury/illness.

Was first aid provided?: This refers to treatment for minor scratches, cuts, burns, splinters and so forth, which do not ordinarily require medical care.

Do you have a second job?: Please specify if you are also working at another organization.

If you have any questions regarding this report, please contact your agency's Worker's Compensation Coordinator or supervisor.