

**Employee Benefits Division
Worker's Compensation Section**



**INSTRUCTIONS FOR
COMPLETION OF FORM EB-49**

**FIRST REPORT OF ACCIDENT
UNDER WORKER'S COMPENSATION ACT**

- # 1. The Department or Division in which the employee was working at time of the injury.
- # 2. Injured employee's health plan.
- # 3. Is the employee entitled to injury pay?

Yes* No⁺

* Check this box only if the following applies:

- 1. The injured employee is **entitled** to injured pay:

Entitled means: the employee has an employment status that provides for injury benefit hours and has injury hours available.

⁺ Check this box only if the following applies:

- 1. The employee's employment status does not provide for injury pay benefit hours.
- 2. The employee has exhausted his/her injury hours.

IMPORTANT NOTE:

DER-Employee Benefits Division-Worker's Compensation Section has the sole responsibility to determine the compensability of Worker's Compensation injuries and therefore the eligibility for payment of injury hours.

You may use discretion in authorizing injury pay for an obvious traumatic injury which is easily traceable to a specific accident while the employee is at work. However when you have doubts, please call the Worker's Compensation Section for guidance before authorizing injury pay.

Never authorize injury pay for occupational disease (ex. stress) or cumulative injury (ex. carpal tunnel). Each of these types of claims must be investigated first by the Worker's Compensation Section.

- 2. How is employee being paid?

Injury* Sick⁺ No Pay^o

*Check this box if the injured employee is being paid injury pay.

⁺Check this box if the injured employee is being paid sick benefits.

^oCheck this box if the injured employee has exhausted injury or sick benefits and/or is off payroll.



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- #4. Include the names of witnesses to the injury. Ask the witnesses to write a statement of what they saw.
- #5. Employee's First, Middle and Last Name (Full Name).
- #6. Employee's 6-digit Employee ID/PeopleSoft Number
- #7. Indicate whether the employee is male or female.
- #8. Injured employee's home telephone number.
- #9. Employee's complete home address.
- #10. Zip code of the employee's home address.
- #11. Indicate the job title that the employee held at the time of the injury.
- #12. Birthdate of the employee.
- #13. Date of hire of injured employee.
- #14. Where the employee was injured, such as field location, office location where the accident happened.
- #15. The employee's average weekly wage rate at the time of the injury.
- #16. Specify the per hour or weekly or monthly or yearly wage rate.
- #17. Indicate if worker was paid overtime. If yes, indicate after how many regular scheduled hours per week.
- #18. Indicate the number of weeks the employee worked in the same type of work. Indicate the gross earnings during the weeks indicated.
- #19. Indicate the employee's usual work schedule when injured.
- #20. Indicate the employer's (the City department) usual full-time schedule for the type of work being performed by the City at the time of the injury, as hours per day; hours per week and number of days per week.
- #21. The date the employee is claiming the injury happened.
- #22. The time of day when injured, indicated by a.m. or p.m.
- #23. The last day the employee worked if he/she is unable to return to work because of injury.
- #24. The date that the employee notified the Department or Division of the job injury.



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#25. The date that the employee returned to work based on the following:

Date returned to work.

Check this box if the employee has returned to work and enter the appropriate date.

Estimated date of return.

Check this box if the employee has not returned to work but you know the expected date of return. Enter the estimated date.

IMPORTANT NOTE:

If the injury will not allow the employee to return to work, check with the treating physician for an estimated date of return and enter that date. You must inform the DER-Employee Benefits Division-Worker's Compensation Section (286-2020) when an employee **does** return to work! This is very important.

#26. If death occurs because of an injury you must notify the DER-Employee Benefits Division-Worker's Compensation Section (286-2020) the same day. The Worker's Compensation Section is required to notify the State of Wisconsin within 24 hours of the death. Please also indicate the date of the death.

#27. Did the employee lose time?

Enter YES or NO

#28. Did the injury occur because of...

Substance Abuse

Failure to use safety devices Was the employee injured because of failure to use safety equipment as required by the Department or Bureau?

Failure to obey rules Did the employee disregard or not follow established safe work procedures?

#29. **IMPORTANT NOTE: This is OSHA required information.**

Please do not omit!

- **Was the employee treated in an emergency room?** Check Yes or No. This is important in determining if the injury will be a recordable injury based on OSHA recordkeeping guidelines.
- **Was the employee treated overnight as an inpatient?** Check Yes or No. This is important in determining if the injury will be a recordable injury based on OSHA recordkeeping guidelines.
- **Case Number from the OSHA Log.** This is vitally important. This case number must match exactly with the corresponding case number on the OSHA 300 log.
- **Name and address of hospital and treating doctor where treatment was rendered.**

#30. Describe the activity as well as the tools, equipment or material the employee was using, such as "climbing a ladder" while carrying roofing materials.



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- #31. What happened to cause this injury or illness? Tell how the injury occurred. Example: When ladder slipped on wet floor, worker fell 20 feet.
- #32. What was the injury or illness? Please state the part of the body that was affected and how it was affected. Be specific! Example: strained back.
- #33. Supervisor of the employee should sign here.
- #34. Phone number of the supervisor should appear here.
- #35. Enter the job title of the person who prepared the report (should be the employee's supervisor).
- #36. Date the EB-49 is signed.

Distribute the EB-49 in the following manner:

For paper reports

- 1) The white copy should be sent to the Worker's Compensation Section (200 East Wells Street, Room 701).
- 2) The yellow copy goes to the Payroll Section.
- 3) The blue copy is for the Department or Division records.

For e-mailed reports

- 1) The EB-49 form can be found on the "Mint." Click on Health and Safety Services then select "Worker's Compensation Report (EB-49)."
- 2) Completed forms may be e-mailed to: WORKCMP EB49

