THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

Employer's Supplemental Report of Injury

This report, indicating disability of an employee of four or more days, shall be filed as soon as possible after date of knowledge of an occupational injury or disease, but no later than ten days thereafter. Consistent failure to make this report available to the labor commissioner and the nearest claims office of your insurance carrier carries an automatic civil penalty of up to $100.00. (RSA 281-A:53) This report shall also be submitted upon employee's return to work.

1. Name of Employer_____Employer's Identification No._____
(9 digit number assigned by proper Federal Agency)

2. Address_____
(No. and St.) (City and State) (Zip Code)

3. Insured by_____

4. Name of Employee_____
(First Name) (Middle Initial) (Last Name) (S.S. Number)

5. Address_____
(No. and St.) (City and State) (Zip Code)

6. Date of injury_____ 20 _____

7. Date Disability began _____20 _____ A.M. _____ P.M._____

8. _____
(Specific dates of disability)

_____
(Specific dates of disability)

9. Has injured returned to work?_____ if so, date and hour _____ A.M._____ P.M._____

10. Is injured person earning same wages as before injury?_____ If not, explain_____

_____

Date of Report_____

Signed by_____

Official Title_____

Tel. No._____

Form No. 13 WCA (7-89) WHITE – LABOR DEPT. CANARY – INSURANCE CLAIMS OFFICE PINK – EMPLOYER'S COPY