Employees' and Physicians' Report of Injury
Prior To Completing This Form You Must
Read The Instructions On The Back Of This Form. **WC-1**

Claim Number: _____
Team Assigned: _____
ICD9: _____

Section I — All Information Must Be Completed by Injured Employee

The receipt of a claim number does not entitle an employee to benefits under WV Workers' Compensation Law. In signing this form, I certify the statements and answers set forth are true and correct. I am aware the law provides for severe penalties if I knowingly provide a false statement or withhold a material fact or statement respecting any information requested by the insurance carrier/service provider.

Initials of Injured Employee: _____

1. Name:
2. Social Security Number: ___ - ___ - ___ Marital Status: ___
3. Injury/Last Exposure Date: ___/___/___ Time: ___ ☐ a.m. ☐ p.m.
4. Address:
   City: ___ County: ___ State: ___ Zip: ___
5. Telephone: (___) ___ - ___ Sex: ☐ Male ☒ Female Date of Birth: ___/___/___
6. Time You Began Work on Date of Injury : ___ ☐ a.m. ☐ p.m.
7. Date Stopped Work for Injury: ___/___/___ Time: ___ ☐ a.m. ☐ p.m.
8. Body Part(s) Injured: ___
9. How Did Injury Occur? *(Specify the cause, what you were doing, and equipment/objects involved):* ___
10. Job Title/Description: ___
11. Did Injury Occur on Employer's Property? ☐ Yes ☒ No Address where injury occurred: ___
12. Employer Name and Address: ___
    City: ___ County: ___ State: ___ Zip: ___
    Telephone Number: (___) ___ - ___ Supervisor's Name: ___
13. If Public Employee, Check One *(If County Board of Education employee, complete the County Board Option Form):*
    ☐ Use Sick Leave ☐ Draw Temporary Total Disability Benefits

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge and belief. I am aware the law, specifically § 61-3-24f, provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I authorize any physician to release to or orally discuss with, either my employer or an authorized agent of the insurance carrier/service provider, any medical records pertaining to the occupational injury or illness for which I am claiming benefits and any prior injury to or disease to the portion of my body for which I am alleging a medical impairment. I acknowledge the provisions of WV Code § 23-4-7 providing authorization for release of medical information by a physician to my employer or employer representative.

Employee's Signature: _____ **Date:** ___/___/___

Section II — All Information Must Be Completed By Initial Provider

I have been informed of my responsibilities under WV Workers' Compensation Law and agree to abide by such in the administration of services provided by the insurance carrier/service provider. I understand the submission of false statements or billing will result in the termination of my contract as well as prosecution under state and federal law.

Initials of Provider/Physician: _____

1. FEIN or SSN: ___ Name of Physician/Hospital: ___
2. Address: ___ Telephone: (___) ___ - ___
   City: ___ County: ___ State: ___ Zip: ___
3. Date you were first consulted for this condition? ___/___/___ Date Employee was/will be able to return to work: ___/___/___
4. Condition is a result of: ☐ Occupational Injury? ☐ Occupational Disease? ☐ Non-Occupational Condition?
5. Disability Period: ☐ Less than 4 days ☐ 1 Week ☐ 2 Weeks ☐ 3 Weeks ☐ More than 4 Weeks
6. Can employee return to modified work? ☐ Yes ☐ No
7. Nature, Body Part and Type of Injury: Diagnosis Code(s) (ICD9-CM) in Order of Severity: ___
   7a. Nature: ___
   7b. Body Part: ___ 7c. Type of Injury: ___
8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No If Yes, Explain: ___
9. Name and address of physician referred to: ___
10. If claimant was hospitalized, where? ___

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically § 61-3-24g, provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge my contractual obligations to the Commission and agree to release any office notes/test results immediately to the Commission.

Physician's Signature: _____ **Date:** ___/___/___

General Instructions for Completing the
WC-1, "Employees' and Physicians' Report of Injury"

- Please Read Carefully -

General Overview: The claim initiation process now involves the filing of two individual forms:
WC-1, Employees' and Physicians' Report of Injury: To be completed by the injured employee and the medical provider.
WC-3, Employers' Report of Injury: To be completed by the employer

A claim cannot be established until the Insurance Carrier/Service Provider has received at least one of the forms listed above. This form should not be used to file occupational pneumoconiosis or hearing loss claims.

Please note that W.V. Code 23-4-1 provides that employees of the state and its political subdivisions are ineligible to receive workers' compensation benefits while drawing sick leave benefits at the same time for the same reason. **You must make your choice known in Question 13 of this form.**

To the Injured Worker: Section I of this form must be completed by you. **When you have completed this form, make a copy for your records, and make a copy to give to your employer.** The initial medical provider is responsible for completing Section II of this form, and your employer is responsible for completing the WC-3, Employers' Report of Injury. Both the provider and employer will be required to send the signed completed forms to the Insurance Carrier/Service Provider. If you do not receive a decision on your claim within **14 days** after sending the form, contact the Insurance Carrier/Service Provider. The responsibility of filing a claim rests with you. To be eligible for benefits, **your claim must be filed with the Commission within six months** from and after the injury or death. If you have any questions, you may contact the Insurance Carrier/Service Provider.

To the Initial Medical Provider: Section II of this form must be completed by you. The timely provision of information regarding the injured worker's condition is vital in deciding eligibility for benefits. Each answer should be as specific as possible. You should immediately send a copy of all records, office notes, and test results regarding the injured worker's exam to the Insurance Carrier/Service Provider. **After completing this form, please make two copies – one for your records and one for the injured worker to take to the employer. Your office is responsible for sending the signed original form to the Workers' Compensation Commission.** If you have any questions, you may contact the Insureance Carrier/Service Provider.

Section I

Question Number	Explanation
3.	This date is defined as either the date you were injured or the date you were last exposed if you are filing an occupational disease claim.
8.	List part(s) of body injured.
9.	Your description of how the injury occurred is reviewed to determine eligibility for benefits.
10.	Describe the job you are currently working. If you are a state, municipal, or county employee, you need to include that in the information. (i.e. construction workers for the state.)
13.	According to the Workers' Compensation Temporary Total Disability Benefits/Sick Leave Policy, if you are absent from work due to a work-related injury, you must choose to receive either Temporary Total Disability benefits (TTD benefits) from Workers' Compensation or paid sick leave. If you elect to receive TTD benefits, you may use sick leave until you receive your initial TTD benefit check; however, this leave will be restored when you reimburse your employer the net value of the paid sick leave used, according to the provisions of this policy.

Section II

Question Number	Explanation
1.	Federal Identification Number or Social Security Number and name, facility or group name you report to Workers' Compensation Commission for billing purposes.
4.	In your opinion, was the patient injured at work, exposed to a disease at work, or is the condition not work related?
7a.	Define injury. (i.e., sprain/strain, fracture, laceration)
7b.	Part(s) of body injured.
7c.	How injury occurred. (i.e., lifting, fall, motor vehicle accident)
8.	Describe in detail what effect, if any, the patient's previous health may have on this injury.

Please mail the completed form to:

When completing this form, enclose attachments if additional space is needed .