Print Reset

Form 301 Information

Email

EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

An employer shall report immediately to the agency on Form WC-100 all injuries, including diseases, which arise out of and in the course of the employment, or on which a claim is made and result in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific losses. In case of death, an employer shall also immediately file an additional report on WC-106. See instructions on reverse side for filing/mailing procedures.

I. EMPLOYEE DATA

1. Social Security Number	2. Date of injury	3. Employee name (Last, First, MI)		
4. Address (Number & Street)		5. City	6. State	7. Zip Code
8. Date of birth (MM/DD/YYYY)	9. Sex ☐ Male ☐ Female	10. Number of dependents	11. Telephone number	

12. Tax filing status: ☐ A. Single ☐ B. Single, Head of Household ☐ C. Married, Filing Joint ☐ D. Married, Filing Separate

II. EMPLOYER/CARRIER DATA

13. Employer name			14. Federal ID Number
Consolidated Electrical Contractors			27-0864676
15. Injury location code	16. Mailing location code	17. UI number	18. Type of business (SIC/NAICS)
		1601067	073
19. Employer street address		20. City	21. State / 22. Zip code
1095A Mak- Tech Dr		Lansing	MI 48906
23. Insurance company name (if employer not self-insured)			24. Insurance company telephone number (if known)
ABC of Michigan			(800) 533-9688

III. INJURY/MEDICAL DATA

25. Last day worked	26. Date employee returned to work (if applicable)		27. Did employee die? ☐ Yes ☐ No	28. If yes, date of death
29. Injury city	30. Injury state	31. Injury county	32. Did injury occur on employer's premises? ☐ Yes ☐ No (If no, see item 53)	
33. Case number from OSHA/MIOSHA log	34. Time employee began work ☐ a.m. ☐ p.m.		35. Time of event ☐ a.m. ☐ p.m.	If time cannot be determined, check here ☐

36. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific.

37. How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet;" "Worker was sprayed with chlorine when gasket broke during replacement"

38. Describe the nature of injury or illness	39. Part of body directly affected by the injury or illness

40. What object or substance directly harmed the employee? Examples: concrete floor, chlorine, radial arm saw. If this question does not apply to the incident, leave it blank.

41. Name of physician or other health care professional	42. Was employee treated in an emergency room? ☐ Yes ☐ No	43. Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

44. If treatment was given away from the worksite, where was it given? (Include name, address, city, state and zip code of facility)

IV. OCCUPATION AND WAGE DATA

45. Date hired	46. Total gross weekly wage (highest 39 of 52)	47. Number of weeks used	48. Value of discontinued fringes
49. Occupation (Be specific)	50. Was employee a volunteer worker? ☐ Yes ☐ No	51. Was employee certified as vocationally handicapped? ☐ Yes ☐ No	
52. Date employer notified by employee	53. If temporary service agency, provide name/address of employer where injury occurred.		

V. PREPARER DATA

I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

54. Preparer's name (Please print or type)	55. Preparer's signature	56. Telephone number	57. Date prepared

Notice to employee: Questions or errors should be reported immediately to the individual listed above in space 54

If you are using this form as a replacement for the Form 301 to document the specifics of an injury or illness for purposes of compliance with the work-related injury and illness logging requirements, follow the instructions in Section A only.

If you are using this form to report a workers' compensation injury, follow the instructions in Section A and B.

Section A

This form can be used in lieu of the MIOSHA Form 301, *Injury and Illness Incident Report.* It is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* (Form 300) and the accompanying *Summary (*Form 300A*)*, these forms help the employer and MIOSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out questions 1-9, 27-28, 33-45 and 54-57.

According to Public Law of 1970 (P.L. 91-596) and Michigan Occupational Safety and Health Act 154, P.A. 1974, Part 11, Michigan Administrative Rule for Recording and Reporting of Injuries and Illnesses, you must keep this form on file for 5 years following the year to which it pertains. **DO NOT mail this form to the Workers' Compensation Agency unless it meets the conditions listed below in Section B.**

Section B

You must complete all questions on this form if the injury or disease results in any of the following: (a) Disability extending beyond seven (7) consecutive days, not including the date of injury; (b) Death; (c) Specific loss. The original form must be mailed to the Workers' Compensation Agency, P.O. Box 30016, Lansing, MI 48909.

Authority: Workers' Disability Compensation Act, 408.31(1)(3) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631	The Department of Labor and Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Corporate Office
1095A Mak-Tech Drive
Lansing, MI 48906

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Supervisor's Report of Accident

Employee involved: _____ Location where accident occurred: _____

Office Location: _____ Time employee reported to work: _____

Machine or equipment employee was working with: _____

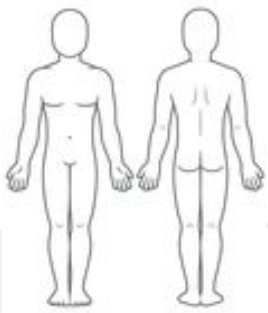
Occupation: _____ Date of accident: _____ Time of accident: _____a.m. p.m.

If an injury occurred, was it treated ☐ On-site ☐ EMS ☐ Clinic ☐ Hospital ☐ Other _____ ☐ Near miss, no injury

Following treatment, the injured employee returned to work:

☐ Same day ☐ Next shift ☐ Lost time at: ☐ Previous job ☐ Modified work

(Circle body part injured)



Completely describe accident (who, what, when, where, why):

_____
_____
_____
_____
_____

Body parts injured: _____

Nature of injury: _____ Accident Type: _____

Analyze and then describe the underlying cause of the accident, in your opinion, considering Policies, Procedures, Equipment, Training, and supervisor practices. (Note employee's carelessness is not a cause) _____
_____
_____
_____
_____

Analyze and describe the Preventive Measures you recommend to address the underlying causes of the accident, considering Company Policies, Procedures, Equipment, Training, and Supervisor Practices. (Note – just telling the injured employee to be more careful after the accident is an incomplete supervision practice) _____
_____
_____
_____
_____

_____ _____ _____ _____
Supervisors Signature Date Employee Signature Date

Person or position who would be responsible for implementing the above: _____

Action(s) or corrective action(s) taken to prevent reoccurrence of the above incident or the like: _____
_____
_____

Date corrective action(s) completed: _____ By: _____