

# WC-1 Employer's Report of Industrial Injury

## System Values

Content Type: \* DCD WC Employee

Scan Mode: Color 300

Scan From: File System

## Document 1 Fields

Document Class: WC-1 Employers Report

Document Type: \* WC-1 Employers Report

Value is Required

DCD Case Number ! \*

Value is Required

Date Received ! \*

New or Amend

Value is Required

Employee Last Name ! \*

Value is Required

Employee First Name ! \*

Employee Middle Initial

Employee Suffix

Federal ID Number

Date of Injury Report

Value is Required

Date of Injury-Illness ! \*

Time of Injury or Illness

Injury or Illness Time

Document Description

Value is Required

Document Date ! \*

DOL Number

Employer Name

Filing Party \* Other

DCD Filing Date

Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a \$5,000 fine. (Sec 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured employee a copy of this report.

## WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

NOTE: DO NOT WRITE IN SHADED BLOCKS

1) DCD Case Number

2) Date Received

3) EE Last Name 4) EE First Name

5) Date of Injury

6) Date of Document

IDENTIFICATION SECTION		NOTE: DO NOT WRITE IN SHADED BLOCKS		CASE NUMBER	
EMPLOYEE NAME - LAST	FIRST	MI	SOC SEC NO	DATE OF BIRTH	MARRIAGE STATUS
ADDRESS		ADDITIONAL ADDRESS INFORMATION (CO)		CITY	STATE
PHONE	OCCUPATION	DATE HIRED	YRS EMPD CODE	DEPARTMENT	PAYROLL COMP CLASS CODE
REGISTERED EMPLOYER		DBA		CITY & COUNTY OF HONOLULU	
ADDRESS		CITY		STATE	ZIP CODE
PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED	DATE OF INJURY/ILLNESS	PREFAB	DOL NUMBER

DETAIL OF INJURY / ILLNESS

TIME OF INJURY/ILLNESS

PLACE OF WORK IF DIFFERENT FROM EMPLOYER MAILING ADDRESS

STATE

ON EMPLOYER'S PREMISES

INDUSTRIAL CODE

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary.)

TIME WORKSHIFT BEGAN

SOURCE OF INJURY

EVENT

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using)

TASK

ACTIVITY

ACCIDENT FACTOR

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g., the machine employee struck against or struck him; the vapor or poison inhaled or swallowed; the chemical that irritated employee's skin. In cases of strains, the object employee was lifting, pulling, etc.)

Emotional distress / Mental stress

DISFIGUREMENT

BURNS

NATURE OF INJURY

PART OF BODY

TIME LOST INFORMATION

DATE DISABILITY BEGAN	WAS EMPLOYEE FORWARDED MEDICAL RECORDS?	Avg Wkly Wage	IF EMPLOYEE BACK TO WORK GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS?	IF EMPLOYEE EMPLOYEE DATE	HOURLY WAGE	MONTHLY SALARY	INJURED IN	REASON FOR
MM / DD / YY	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	1592.96	MM / DD / YY	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	MM / DD / YY		6902.83		

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN

ADDRESS

PHYSICIAN I.D. CODE

NAME OF MEDICAL FACILITY

ADDRESS

INPATIENT OVERNIGHT?  YES  NO

EMERGENCY ROOM ONLY?  YES  NO

INSURANCE

CARRIER I.D.

NAME OF WC INSURANCE CARRIER

NAME OF ADJUSTING COMPANY

IF LIABILITY DENIED - WHY?

IS LIABILITY DENIED?

Self Insured

City & County of Honolulu

Denied Pending Investigation

POLICY NO.

POLICY PERIOD

ADJUSTER NAME

CARRIER CASE NO.

SELF-INSURED

01/01/1901 - 12/31/2050

Francene Ching

19

SIGNATURE

ADJUSTER I.D.

MEDICAL DEDUCTIBLE

for Fran

Sr. Examiner

\$0.00

WC-1 (Rev. SEP11)

7) Filing Party is Defaulted to Other

# WC-2 Physician's Report

**System Values**

Content Type: \* DCD WC Employee

Scan Mode: Color 300

Scan From: File System

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**Document 1 Fields**

Document Class: WC-1 Employers Report

Document Type: \* WC-1 Employers Report

**Value is Required**

DCD Case Number ! \*

Date Received ! \*

New or Amend

**Value is Required**

Employee Last Name ! \*

**Value is Required**

Employee First Name ! \*

Employee Middle Initial

Employee Suffix

---

Federal ID Number

Date of Injury Report

**Value is Required**

Date of Injury-Illness ! \*

Time of Injury or Illne

Injury or Illness Time

---

Document Description

**Value is Required**

Document Date ! \*

DOL Number

Employer Name

Filing Party \* Other

DCD Filing Date



STATE OF HAWAII  
 DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
 DISABILITY COMPENSATION DIVISION  
 Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813  
**FORM WC-2 PHYSICIAN'S REPORT**

Note: PLEASE DO NOT WRITE IN SHADED BLOCKS

1	2	3	4	5	6	Case Number
First	First & Final	Final	Interim	Consulting	Rate	DCD Case Number
						Date this report received
						Mo. / Day / Yr.

Employer Name and Address 808 OF HONOLULU DEPT OF 1061 RICHARDS ST HONOLULU, HI 96813	Carrier's Name and Address
Patient's Name and Address	Your Name, Address and Telephone No. PAID STRAVE MEDICAL CENTER 500 S. KING ST. HONOLULU 96813
Patient's Social Security Number	Physician's ID 52
Date of Injury/Illness Mo. / Day / Yr.	Date of First Treatment Mo. / Day / Yr.
	If patient expired, give date Mo. / Day / Yr.

- |  | Yes                                 | No                                  |
|--|-------------------------------------|-------------------------------------|
| 1. Are you the attending physician?                        | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 2. Has the patient been burned?                            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 3. Is there a possibility of other disfigurement?          | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 4. Do you think physical rehabilitation will be necessary? | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 5. Do you think medical rehabilitation will be necessary?  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |

State in patient's own words where and how the accident occurred:  
 THE SITUATION AT WORK WAS SPINNING OUT OF CONTROL AFTER STAFF REDUCED FROM 7 TO 2 IN 2018. WITH HEAVY CASE LOAD, I BECAME PREOCCUPIED WITH WHAT I HAD TO DO, COULDN'T REST MY MIND, UNABLE TO SLEEP

Give accurate description and extent of injury: specify all parts of the body involved and state objective findings.  
 WORK STRESS AFFECTED MENTAL STATUS: HIGH ANXIETY, AND AFFECTED PHYSICAL SYMPTOMS: INSOMNIA, CHEST PRESSURE

Is accident mentioned above the only cause of patient's condition?  Yes  No, state contributing causes.

Page 2 of 2 for WC-2

Patient  was  will be able to resume  light work  regular work on: NOT ABLE TO WORK FOR INDEFINITE PERIOD

Patient stopped treatment without orders on \_\_\_\_\_ Patient discharged as cured on \_\_\_\_\_

Describe any permanent defect or disfigurement (include scars, discolorations, deformities, etc.)  None

Final Diagnosis:  
ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD

Physician Signature \_\_\_\_\_ Date: **6) Document Date**

7) Filing Party is Defaulted to Other

# WC-3 Carrier's Case Report

**System Values**

Content Type: \* DCD WC Employee

Scan Mode: Color 300

Scan From: File System

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**Document 1 Fields**

Document Class: WC-3 Carriers Case Report

Document Type \* WC-3 Carriers Case Report

DCD Case Number \* 22040074

**Value is Required**

Date Received ! \*

New or Amend

Claimant Last Name \* YAMASHITA

Claimant First Name \* JOHN

Claimant Middle Initial A

Claimant Suffix

Identification Type Extraction

Identification Number 575001234

Date of Injury-Illness \* 7/17/2019

Claimant Address

Claimant City

Claimant State

Claimant Zip Code

Claimant Email Address

Claimant Phone Number

Registered Employer Name

DBA

Employer Address

Employer City

Employer State

Employer Zip Code

Document Description

**Value is Required**

Document Date ! \*

DOL Number

Employer Name

Filing Party \* Other

DCD Filing Date

## Front Page

**WC-3 CARRIER'S CASE REPORT**  
(NOTE: DO NOT WRITE IN SHADED BLOCKS)

Case No. **29912345**

Date Received  
Mo. / Day / Yr.  
30 / 01 / 1999

CLAIMANT NAME AND ADDRESS  
**3) & 4) Claimant Name  
Address  
City, State, Zip**

SOC. SEC. NO. **575-00-1234**

DATE OF INJURY/ILLNESS **5) 3/2/1999**

EMPLOYER Hawaii Department of Education

CARRIER Hawaii Department of Education

ADJUSTER Avena K-Aloha  
Po Box 2360  
ADDRESS Honolulu, HI 96804

INDIVIDUAL TO CONTACT Avena K-Aloha

TELEPHONE NO. (808)587-4093

CHECK ONE:

- DATE OF FIRST INCOME REPLACEMENT PAYMENT: MO. / DAY / YR.
- REOPEN CASE
- HEARING REQUESTED
- NO LOST TIME/MEDICAL ONLY - PAYMENT DATE MO. / DAY / YR.
- FINAL PAYMENT TO PREVIOUSLY ENDED CASE FOR
- YEAR ENDED REPORT FOR 2011
- FINAL REPORT (COPY TO EMPLOYEE) FOR

NOTE: WHEN 4, 5, 6, & 7 ARE CHECKED, PAYMENT BLOCK MUST BE FILLED IN.

RETURN TO WORK DATE: MO. / DAY / YR.

WEEKLY COMP. RATE 258.32

BENEFIT PAYMENTS	Days	Payments Not Previously Reported	Prior Payments	Total Payments Made to Date
1. Temporary Total	322	\$	\$ 118237.34	\$ 118237.34
2. Temporary Partial		\$	\$	\$
3. Permanent Total		\$	\$	\$
4. Permanent Partial		\$ 13469.61	\$ 44663.39	\$ 58133.00
5. Death		\$	\$	\$
6. Disfigurement		\$	\$ 3500.00	\$ 3500.00
7. Medical/Other Costs		\$ 52.68	\$ 77061.16	\$ 77113.84
8. Services of Attendant		\$	\$	\$
9. Rehabilitation		\$	\$ 21723.76	\$ 21723.76

Carrier's Comments:  
TTD: 2/12/2011 - 12/31/2011. 1 DAY OF CREDIT OF \$84.80 RTW 11/16/2011.

Medical Deductible:

\*List Date(s) of Disability in Carrier's Comments Section. I hereby certify the accuracy of all of the above statements.

NOTICE TO EMPLOYEE: With the final payment of compensation (as indicated hereon) on your industrial injury of month day year identified as Case No. the case shall be closed. This determination shall not constitute a bar to your reopening rights as provided by section 306-69, HRS, nor to future medical benefits.

SIGNATURE *[Signature]*

POSITION Pers. Mgmt. Spec.

DATE **6) 01/09/2012**

## Back Page

**2) Date Received**

13 AUG -1 P12:38

**WC-5 Employee Claim for Benefits**

*System Values*

Content Type: \* DCD WC Employee  
 Scan Mode: Color 300  
 Scan From: File System

*Document 1 Fields*

Document Class: WC-5 Employees Claim fc  
 Document Type: \* WC-5 Employees Claim fc  
 Value is Required  
 DCD Case Number ! \*  1  
 Value is Required  
 Date Received ! \*  2  
 New or Amend  
 Value is Required  
 Last Name ! \*  3  
 Value is Required  
 First Name ! \*  4  
 Middle Initial  
 Suffix

Was Employee fur  
 Lost time off from work as  
 Value is Required  
 Date of Injury-Illness ! \*  5  
 Time of Injury or Illne

Document Title  
 Document Description  
 Value is Required  
 Document Date ! \*  6  
 DOL Number  
 Filing Party \* Other  
 DCD Filing Date



STATE OF HAWAII  
 DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
 DISABILITY COMPENSATION DIVISION  
 Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

1) DCD Case Number *mc 219*

**FORM WC-5  
 EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS**

Injured Person  
 Name: 3) LastName 4) FirstName  
 Address: Honolulu, Hawaii 96817  
 Occupation: Advocate  
 Telephone No. ( 808 ) Social Security No.

Employer  
 Name  
 Department of  
 Address: 7060 Honolulu, HI 96813  
 Nature of Business Telephone No. ( 808 )

Insurance Carrier  
 Name  
 City and County of Honolulu  
 Address: 650 S.King Street, Honolulu, HI 96813

DISABILITY COMPENSATION DIVISION

2) Date Received: Date Stamp

Injury  
 Date of Accide: 5) Date of Injury Time of Injury X a.m. p.m. Date Disability Began 1/8/19

If not on employer's premises, indicate place where accident occurred  
 Describe how accident occurred  
 Work related stress, but not limited to heavy caseload, lack of support and lack of resources  
 Describe injury/illness  
 Emotional distress, mental stress

Reason for filing:  
 Employer has not filed WC-1  Reopening of old claim  Insurance carrier has not paid benefits  
 Others (explain)  
 Employer has not informed me of the status of my claim

Page 2 of 2 for WC-5

(Rev. 10/05)

Represented by \_\_\_\_\_ / Attorney  
 ATTORNEY/UNION AGENT SIGNATURE OF CLAIMANT  
 Address: Richards St.  
 Honolulu, HI 96813  
 tele: (808)

FEB 20 2019

6) Date of Document

Auxiliary aids and services are available upon request. Please call: (808) 586-9174; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.

Visit our Website at [www.hawaii.gov/labor](http://www.hawaii.gov/labor) for ALL interactive and downloadable forms.

(Rev. 10/05)