Employer: Diocese of Alexandria

_____ - _____ - _____
Employee Social Security Number

Employee Date of Birth

72-0491102
Employer Federal ID Number

EMPLOYER REPORT
OF
INJURY/ILLNESS

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately. **Forms for cases resulting in more than 7 days of disability or death** are to be sent to the OWCA **by the 10th day after the incident** or as reqested by the OWCA.

PURPOSE OF REPORT: (Check all that apply)

- ☐ More than 7 days of disability
- ☐ Injury resulted in death
- ☐ Amputation or disfigurement
- ☐ Possible dispute
- ☐ Lump Sum Compromise/Settlement
- ☐ Other
- ☐ Medical only (no copy needed by OWCA)

1.Date of Report MM/DD/YY	2. Date / time of Injury MM/DD/YY Time ☐AM ☐PM	3. Normal Starting Time Day of Accident ☐AM ☐PM	4.If Back to Work - Give date MM/DD/YY	5. At same wage? ☐Yes ☐No	DO NOT WRITE IN THIS COLUMN
6. If Fatal Injury, Give Date of Death MM/DD/YY	7. Date Employer Knew of Injury MM/DD/YY	8. Date Disability began MM/DD/YY	9. Last Full Day Paid MM/DD/YY		Date Received
10. Employee Name First Middle Last		11. ☐Male ☐Female	12. Employee Phone # ( )		S.I.C.
13. Address and Zip Code			14. Parish of Injury		State-Parish
15. Date of Hire	16. Age of illness/injury	17. Occupation	18. Dept/Division Employed		Occupation
19. Place of Injury-Employer's Premises ? ☐Yes ☐No	20. If No, Indicate Location-Street, City, Parish and State				Nature
21. What work activity was the employee doing when the injury occurred? (Give weight, size and shape of materials or equipment involved). Tell what employee was doing with them. Indicate if correct procedures were followed.					Part of Body Source Event NCCI
22.What caused injury to happen? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)					
23. Part of Body Injured and Nature of Injury or Illness (ex. left leg; multiple fractures)					24. If Occ. Disease-Give Date Diagnosed
25. Physician and Address				26. If Hospitalized, give name & address of facility	
27. Employer's Name				28. Person Completing This Report - Please print	
29. Employer's Address and Zip Code				30. Employer's Telephone Number ( )	
31. Employer's Mailing Address-If Different From Above				32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.	
33. Wage Information (optional)Employee was paid ☐Daily ☐Weekly ☐Monthly ☐Other. The average weekly wage was $ _____ per week.					

Name of Workers' Compensation Insurer: SELF-INSURED
Fax, Email or Mail Claim to:
AVIZENT
1625 West Causeway Approach Mandeville, LA 70471
CLAIM REPORTING FAX: (985)624-8684 EMAIL: scandocs@fara.com
Phone: (985)624-6716 or (800)259-8388

COMPLETE BOTH SIDES
DOA 7/2013
LDOL-WD-1007
Rev.1/98

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of $500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to $10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than $500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to $10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000.

EMPLOYER CERTIFICATION

I certify that I can read the English language, that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)	Signature Date
DIOCESE OF ALEXANDRIA	**PO BOX 7417, ALEXANDRIA, LA 71306**
(318) 445-2401	**SELF-INSURED**
Phone Number	Insurance Policy Number
	- -
Employee Name	Employee Social Security Number

Fax, Email or Mail Claim to:

AVIZENT
1625 West Causeway Approach
Mandeville, LA 70471
CLAIM REPORTING FAX: (985)624-8684
EMAIL: scandocs@fara.com
Phone: (985)624-6716 or (800)259-8388

COMPLETE BOTH SIDES

LDOL-WC-1025.ER
REV. 1/98