Workers’ Compensation

Reporting Injury
You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death
In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1. the disease manifests itself.
2. the employee is disabled as a result of the disease.
3. the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee’s employer within one year of:

1. the date of death.
2. the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice
In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers’ compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians
In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim
In order to preserve your right to benefits under the Louisiana Workers’ Compensation Law, you must file a formal claim with the Office of Workers’ Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information
If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers’ Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

GuideOne Insurance
1111 Ashworth Road
West Des Moines, IA 50265

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

Employer
NORTHWOOD UNIVERSITY
% DAVE BENDER-RISK MGR
4000 WHITING DR
MIDLAND MI 48640

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer’s place of business.

Revised 5/2003

Louisiana Workforce Commission
www.LAWORKS.net
## 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.

### PURPOSE OF REPORT:

- More than 7 days of disability
- Medical Only
- Injury resulted in death
- Lump Sum Compromise/Settlement
- Amputation or disfigurement

### DO NOT WRITE IN THIS COLUMN

1. Date of Report MM/DD/YY
2. Date / time of Injury MM/DD/YY
3. Normal Starting Time AM PM
4. Day of Accident AM PM
5. If Back to Work - Give date MM/DD/YY
6. At same wage? Yes No

### Date Received

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

### NAICS:

10. Employee Name First Middle Last
11. Male Female

12. Employee Phone #

13. Address and Zip Code

14. Parish of Injury

15. Date of Hire

16. Date of Birth

17. Occupation

18. Dept/Division Employed

19. Place of Injury-Employer's Premises? Yes No

20. If No, indicate Location-Street, City, Parish and State

22. What caused injury to happen? (Describe fully the events which resulted in injury or disease. Explain what happened and how it happened. Name any objects or substances involved and explain how they were involved. Give full details of 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.

### Download Employer's Certificate of Compliance

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**WC 8486e (8-06) UNIFORM**