



Employer's Report of Injury

For BrickStreet Use Only	
Claim Number:	
Team Assigned:	

EMPLOYER INFORMATION	1. BrickStreet Insurance Policy Number:		2. FEIN or SSN:		3. Nature of Business:		
	4. Employer's Name:						
	5. Address:						
	City:		State:		Zip:		6. Telephone: - -

EMPLOYEE INFORMATION	1. Name: Last		First		MI		6. Date Hired:	
	2. Address:						7. Telephone: - -	
	City:		State:		Zip:		8. Social Security Number:	
	3. Date of Birth:			4. Sex: <input type="checkbox"/> M <input type="checkbox"/> F			9. Marital Status:	
	5. Injured Employee is: (check all that apply) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Volunteer <input type="checkbox"/> Owner / Partner <input type="checkbox"/> Officer <input type="checkbox"/> Retired – Date Retired:						10. Employee's Occupation / Job Title:	

INFORMATION ABOUT INJURY / DISEASE	1. Date of Injury or Last Exposure:		Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		5. Witnesses to Injury:	
	2. Date Employer Notified of Injury or Disease:					
	3. Supervisor to Whom Injury or Disease Reported:					
	4. If Injury was Fatal, Indicate Date of Death:					
	6. Did Injury Occur on Employer's Property? <input type="checkbox"/> Yes <input type="checkbox"/> No		Address or location where injury occurred:			
	7. What was the Employee Doing When Injury Occurred? (loading truck, walking down stairs, etc.)					
	8. How did the Injury or Disease Occur? (Be specific, include time that employee began work on date of injury, any equipment, tools substances or objects connected to the injury; attach additional sheet(s) if necessary)					
	9. Nature of Injury or Disease (cut, bruise, strain, etc.)					
	10. Body Part(s) Injured:					
	11. Are you Aware of, or Do You Suspect, a Prior Injury to this Body Part? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	12. Do you Have Reason to Question this Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "yes," attach a specific explanation to this form.)					
	13. Location of Initial Treatment:		Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No		Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	

WAGE AND LOST TIME INFORMATION	1. Last Day Worked After Occupational Injury or Disease:					
	2. Number of Work Days Lost:		3. Date of Return to Work:		4. Hours Worked Per Week:	
	5. Is Light Duty Available? <input type="checkbox"/> Yes <input type="checkbox"/> No		6. Wage on Date of Injury: \$ Per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month			
	7. Are Wages Being Paid to Injured Employee During Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. If Employee Has Returned to Work, is it Alternative or Modified Work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," indicate current wage: \$ Per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month			
	9. Daily Rate of Pay on Date of Injury: \$			and best quarter wages of preceding four quarters: \$		

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 West Virginia Code § 61-3-24e provides for severe penalties if I knowingly certify a false report or statement and / or withhold a material fact regarding any information requested. I acknowledge the provisions of the aforementioned code and the severe penalties for knowingly with fraudulent intent aiding or abetting anyone in securing or attempting to secure benefits to which he or she is not entitled.	
Print Name:	Title:
Signature:	Date:

**General instructions for completing the
BI-3, "Employer's Report of Injury"**

Please Read Carefully

To the Employer: W.V. Code 23-4-1b requires you to report the injury to your carrier within five days of receipt of notification from an employee's injury.

This form should not be used to file occupational pneumoconiosis or hearing loss claims.

To report a claim, please contact BrickStreet at 1-866-452-7425. If completing this form, make a copy for your records.

Return completed form to: **BrickStreet Mutual Insurance
P. O. Box 3151
Charleston, WV 25332-3151**

When completing this form, please attach additional pages if space is needed. Also attach any witness statements and reports you wish to submit.