EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
PO Box 30016, Lansing, MI 48909

An employer shall report immediately to the bureau on Form BWC-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 BWC-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	
15. Injury location code	16. Mailing location code	17. UI number	18. Type of business (SIC/NAICS)	
19. Employer street address		20. City	21. State	22. Zip code
23. Insurance company name (if employer not self -insured)			24. Insurance company telephone number (if known)	

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 line 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. Once finished, save this to your computer and email it to info@insurancebyfrost.com.

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 Bureau of Workers' & Unemployment Compensation unless it meets the conditions listed below in Section B. Mail it to info@insurancebyfrost.com.**

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 Bureau of Workers' & Unemployment Compensation, 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	Department of Consumer & Industry Services 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.

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Form #	BWC-100	Form Name:	Employer's Basic Report of Injury

When Required:

An employer shall report immediately to the bureau on Form BWC-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**. In case of death, an employer shall also immediately file an additional report on BWC-106.
(c) **Specific losses**.

Required Fields:

The BWC-100 (referred to as a 100) is filed by the employer.

This form is fairly self-explanatory. The following, however, should clarify several items on the form:

14 Federal I.D. Number
The Federal Employer Identification Number assigned by the U.S. Department of Treasury.

15 Injury Location Code
The bureau assigns location codes to any employer with more than one location. If the preparer knows the code that corresponds to the location of injury, it should be entered in this field. Otherwise, it may be left blank.

16 Mailing Location Code
If the preparer knows the location code (see above) that corresponds to the address where any bureau correspondence on this form should be sent, it should be entered in this field. Otherwise, it may be left blank.

17 UI Number
The unemployment insurance number assigned to each employer by the Michigan Unemployment Agency (formerly Michigan Employment Security Commission).

18 Type of Business (SIC/NAICS)
The Standard Industrial Classification code published by U.S. Department of Labor which correlates to the employer's type of business. This has recently been renamed the North American Industry Classification System (NAICS) code.

All applicable fields must be completed.

✓ Forms will be returned if fields 1- 3, 13, 19-22 are not completed.

✓ You will receive a letter if fields 4, 8, 27, 34, and 35 are not completed.

Instructions:

Completing the Form:

✓ Select the hand tool from the Acrobat toolbar menu. You can use the hand tool to move the page around so that you can view all areas.

✓ Position the hand pointer inside a form field and click. The I-beam pointer allows you to type text.

✓ To complete the "red boxes," using your mouse, position the cursor over the applicable box until the pointing finger icon appears and click.

✓ Press Tab to accept the field change and go to the next field, or
Press Shift + Tab to accept the field change and go to the previous field.

✓ Use your mouse to select an area of the form that is not inside a form field before printing your form.

✓ To print, be sure to use the printer button on the Acrobat toolbar menu to print the form instead of your web browser's print function. You may need to select the "Print as image" option in the print dialog box to print the completed form.

✓ To print the completed form only, select "Print Current Page" or "Pages From: 1 To: 1"

NOTE: Please complete all date fields with the **MM/DD/YYYY** format.

If you have any comments on this fill-in form, please send them to wcinfo@michigan.gov. Please include the keyword "Fill-In Form 100" with your comments.

How to Submit This Form:

The Michigan Bureau of Workers' & Unemployment Compensation needs to receive only those forms that meet the **When Required** criteria mentioned above. If an injury does not involve seven or more days of wage loss, and your insurance carrier does not provide medical-only claim forms, you may complete this form and submit it to your workers' compensation insurance carrier **only**.

If the injury does meet the criteria mentioned above:

✓ Print the completed form

✓ Sign and make 3 copies
- Give a copy of the report to the employee
- Mail a copy of the report to your workers' compensation insurance carrier
- Keep a copy for your records
- Mail the original of the signed Form 100 to:

Bureau of Workers' & Unemployment Compensation
P O Box 30016
Lansing MI 48909