EMPLOYER'S BASIC REPORT OF INJURY

Michigan Department of Labor
Bureau of Workers' Disability Compensation
P.O. Box 30016, Lansing, MI 48909

AN EMPLOYER SHALL REPORT IMMEDIATELY TO THE BUREAU ON FORM MDL-1-100 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 MDL-1-106.

I. EMPLOYEE DATA

1. SOCIAL SECURITY NUMBER
2. DATE OF INJURY
3. EMPLOYEE NAME (LAST, FIRST, MI)
4. ADDRESS (NUMBER AND STREET)
5. CITY
6. STATE
7. ZIP CODE
8. DATE OF BIRTH (MM/DD/YY)
9. SEX ☐ MALE ☐ FEMALE
10. NUMBER DEPENDENTS
11. TELEPHONE NUMBER ( )
12. WORK PERMIT DATE IF UNDER AGE 18
13. TAX FILING STATUS ☐ A. SINGLE ☐ B. SINGLE, HEAD OF HOUSEHOLD ☐ C. MARRIED, FILING JOINT ☐ D. MARRIED, FILING SEPARATE

II. CURRENT EMPLOYER DATA

14. EMPLOYER NAME
15. FEDERAL I.D. NUMBER
16. INJURY LOCATION CODE
17. MAILING LOCATION CODE
18. MESC NUMBER
19. TYPE OF BUSINESS (SIC)
20. ADDRESS (NUMBER AND STREET)
21. CITY
22. STATE
23. ZIP CODE

III. SECOND EMPLOYER DATA

24. SECOND EMPLOYER NAME
25. SECOND EMPLOYER AWW $
26. NUMBER WEEKS USED
27. ADDRESS (NUMBER AND STREET)
28. CITY
29. STATE
30. ZIP CODE

IV. ALLEGED INJURY DATA

31. LAST DAY WORKED
32. DATE EMPLOYEE RETURNED TO WORK (IF APPLICABLE)
33. DID EMPLOYEE DIE? ☐ YES ☐ NO
34. INJURY CITY
35. INJURY STATE
36. INJURY COUNTY
37. DID INJURY OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ *NO (*IF NO, SEE ITEM 50)
38. DESCRIBE THE NATURE OF INJURY OR ILLNESS (EXAMPLE: AMPUTATION, BURN, CUT, FRACTURE)
39. PART OF BODY DIRECTLY AFFECTED BY THE INJURY OR ILLNESS (EXAMPLE: HAND, ARM, CIRCULATORY SYSTEM)
40. DESCRIBE THE EVENTS WHICH CAUSED THE INJURY (EXAMPLE: FELL, OPERATING MACHINERY, CHEMICAL EXPOSURE)
41. NAME THE OBJECT OR SUBSTANCE WHICH DIRECTLY INJURED THE EMPLOYEE (EXAMPLE: KNIFE, ACID, FLOOR, OIL)

V. OCCUPATION AND WAGE DATA

42. DATE HIRED
43. TOTAL GROSS WEEKLY WAGE (HIGHEST 39 OF 52) $
44. NUMBER WEEKS USED
45. VALUE OF DISCONTINUED FRINGES $
46. OCCUPATION (BE SPECIFIC)
47. WAS EMPLOYEE A VOLUNTEER WORKER? ☐ YES ☐ NO
48. WAS EMPLOYEE CERTIFIED AS VOCATIONALLY HANDICAPPED? ☐ YES ☐ NO
49. DATE EMPLOYER NOTIFIED BY EMPLOYEE
50. IF TEMPORARY SERVICE AGENCY, PROVIDE NAME/ADDRESS OF EMPLOYER WHERE INJURY OCCURRED.

VI. PREPARER DATA I CERTIFY THAT A COPY OF THIS REPORT HAS BEEN GIVEN TO THE EMPLOYEE

51. PREPARER'S SIGNATURE
52. TELEPHONE NUMBER ( )
53. DATE PREPARED

NOTICE TO EMPLOYEE: QUESTIONS OR ERRORS SHOULD BE REPORTED IMMEDIATELY TO THE INDIVIDUAL LISTED ABOVE IN LINE 51.

AUTHORITY: WORKERS' DISABILITY COMPENSATION ACT, R408.31(1)(3)
COMPLETION: MANDATORY
PENALTY: WORKERS' DISABILITY COMPENSATION ACT, 418.631

THE DEPARTMENT OF LABOR WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, HANDICAP, OR POLITICAL BELIEFS.

MDL-1-100 (3/93) FORMERLY FORM 100