

**Universal wording updates to improve clarity and intent were made to all FIG text for this form on 12/30/2008.**

Section Name	Field Name	Field and/or Section Description
<b>TITLE</b> <b>ACORD 4 WI (2003/04)</b>	<b>Wisconsin Employer's First Report of Injury or Disease</b>	The title of the form. ACORD 4 WI, Wisconsin Employer's First Report of Injury or Disease, is used to report a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. Instructions for the completion of ACORD 4 WI are found on page 2 of this form.
<b>EMPLOYEE INFORMATION</b>	<b>Name (First, Middle, Last)</b>	Enter text: The employee's first name (given name).
<b>EMPLOYEE INFORMATION</b>		Enter text: The employee's middle name or initial (other given name).
<b>EMPLOYEE INFORMATION</b>		Enter text: The employer's last name (surname).
<b>EMPLOYEE INFORMATION</b>	<b>Social Security Number</b>	Enter identifier: The tax identifier of the employee.
<b>EMPLOYEE INFORMATION</b>	<b>Sex Male</b>	Check the box (if applicable): Indicates the employee is male.
<b>EMPLOYEE INFORMATION</b>	<b>Sex Female</b>	Check the box (if applicable): Indicates the employee is female.
<b>EMPLOYEE INFORMATION</b>	<b>Employee Home Telephone Number</b>	Check the box (if applicable): Indicates the employee is married.
<b>EMPLOYEE INFORMATION</b>	<b>Employee Street Address</b>	Enter text: The first address line of the employee's mailing address.
<b>EMPLOYEE INFORMATION</b>	<b>City</b>	Enter text: The city of the employee's mailing address.
<b>EMPLOYEE INFORMATION</b>	<b>State</b>	Enter code: The state or province code of the employee's mailing address.
<b>EMPLOYEE INFORMATION</b>	<b>Zip</b>	Enter code: The postal code of the employee's mailing address.
<b>EMPLOYEE INFORMATION</b>	<b>Occupation</b>	Enter text: The occupation of the employee.
<b>EMPLOYEE INFORMATION</b>	<b>Birth Date Month</b>	Enter number: The month of the employee's birth.
<b>EMPLOYEE INFORMATION</b>	<b>Birth Date Day</b>	Enter number: The day of the month of the employee's birth.
<b>EMPLOYEE INFORMATION</b>	<b>Birth Date Year</b>	Enter year: The year of the employee's birth.

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EMPLOYEE INFORMATION	Date of Hire	Enter date: The hire date of the employee.
EMPLOYEE INFORMATION	County and State where accident or exposure occurred	Enter text: The loss location's county name.
EMPLOYEE INFORMATION		Enter code: The loss location's state or province code.
EMPLOYER INFORMATION	Employer Name	Enter text: The named insured(s) as it/they will appear on the policy declarations page.
EMPLOYER INFORMATION	WI Unemployment Ins. Acct. No.	Enter identifier: The named insured's state unemployment account number.
EMPLOYER INFORMATION	Self-Insured? Yes	Check the box (if applicable): Indicates the insured is self-insured, in whole or in part.
EMPLOYER INFORMATION	Self-Insured? No	Check the box (if applicable): Indicates the insured is not self-insured, in whole or in part.
EMPLOYER INFORMATION	Nature of Business (Specific Product)	Enter text: The description of the nature/type of business.
EMPLOYER INFORMATION	Employer Mailing Address	Enter text: The named insured's mailing address line one.
EMPLOYER INFORMATION	City	Enter text: The named insured's mailing address city name.
EMPLOYER INFORMATION	State	Enter code: The named insured's mailing address state or province code.
EMPLOYER INFORMATION	Zip	Enter code: The named insured's mailing address postal code.
EMPLOYER INFORMATION	Employer FEIN	Enter identifier: The tax identifier of the named insured.
EMPLOYER INFORMATION	Name of Workers Compensation Insurance Company or Self-Insured Employer	Enter text: The insurer's full legal company name(s) as found in the file copy of the policy. Use the actual name of the company within the group to which the policy has been issued. This is not the insurer's group name or trade name.
EMPLOYER INFORMATION	Insurer FEIN	Enter identifier: The tax identifier of the insurer.
EMPLOYER INFORMATION	Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer	Enter text: The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

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EMPLOYER INFORMATION		Enter text: The first address line of the claim administrator's mailing address.
EMPLOYER INFORMATION		Enter text: The city of the claim administrator's mailing address.
EMPLOYER INFORMATION		Enter code: The state or province code of the claim administrator's mailing address.
EMPLOYER INFORMATION		Enter code: The postal code of the claim administrator's mailing address.
EMPLOYER INFORMATION	TPA FEIN	Enter identifier: The tax identifier of the claim administrator.
WAGE INFORMATION	Wage at Time of Injury	Enter amount: The employee's average wage amount.
WAGE INFORMATION	Specify per hr., wk., mo., yr., etc.	Enter code: Indicates the frequency at which the average wage amount is paid.
WAGE INFORMATION	Is worker paid overtime ? Yes	Check the box (if applicable): Indicates the employee receives overtime pay.
WAGE INFORMATION	Is worker paid overtime ? No	Check the box (if applicable): Indicates the employee does not receive overtime pay.
WAGE INFORMATION	If "Yes", after how many hours per week.	Enter number: The number of hours an employee must work per week prior to being paid for overtime.
WAGE INFORMATION	Check boxes if employee received: Meals	Check the box (if applicable): Indicates the employee received meals in addition to their wages.
WAGE INFORMATION	Number of Meals per Week	Enter number: The number of meals per week the employee received.
WAGE INFORMATION	Check boxes if employee received: Room	Check the box (if applicable): Indicates the employee received a room in addition to their wages.
WAGE INFORMATION	Number of Days per Week	Enter number: The number of days per week the employee received a room..
WAGE INFORMATION	Check boxes if employee received: Tips	Check the box (if applicable): Indicates the employee received tips in addition to their wages.
WAGE INFORMATION	Average Weekly Amount	Enter amount: The average weekly amount of tips the employee received.
WAGE INFORMATION	Employee's Work Schedule when injured: Start Time	Enter time: The employee's scheduled start time when injured.
WAGE INFORMATION	Employee's Work Schedule when injured: Hours per Day	Enter number: The number of hours per day the employee was working when injured.
WAGE INFORMATION	Employee's Work Schedule when injured: Hours per Week	Enter number: The number of hours per week the employee was working when injured.
WAGE INFORMATION	Employee's Work Schedule when injured: Days per Week	Enter number: The number of days per week the employee was working when injured.

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WAGE INFORMATION	Employee's Normal Full-Time Schedule for Injured's Work: Start Time	Enter time: The employee's normal full time scheduled start time.
WAGE INFORMATION	Employee's Normal Full-Time Schedule for Injured's Work: Hours per Day	Enter number: The number of hours per day the employee works when on their normal full-time schedule.
WAGE INFORMATION	Employee's Normal Full-Time Schedule for Injured's Work: Hours per Week	Enter number: The number of hours per week the employee works when on their normal full-time schedule.
WAGE INFORMATION	Employee's Normal Full-Time Schedule for Injured's Work: Days per Week	Enter number: The number of days per week the employee works when on their normal full-time schedule.
WAGE INFORMATION	Number of Weeks	Enter number: The number of weeks works in the 52 weeks prior to the injury/illness occurring.
WAGE INFORMATION	Gross Amount Excluding Tips	Enter amount: The gross wages amount, excluding tips, in the 52 weeks prior to the injury/illness occurring.
WAGE INFORMATION	If Piece Work Number of Hours Excluding Over Time	Enter number: The number of pieces per hour, excluding overtime, in the 52 weeks prior to the injury/illness occurring.
WAGE INFORMATION	Schedule Hours per Week	Enter number: The number of hours scheduled per week for a part-time employee.
WAGE INFORMATION	Are there other part-time workers doing the same work with the same schedule? Yes	Check the box (if applicable): Indicates there are other part-time workers doing the same work with the same schedule.
WAGE INFORMATION	Are there other part-time workers doing the same work with the same schedule? No	Check the box (if applicable): Indicates there are not other part-time workers doing the same work with the same schedule.
WAGE INFORMATION	Number of part-time employees doing the same kind of work.	Enter number: The number of other part-time workers doing the same work with the same schedule.
WAGE INFORMATION	Number of full-time employees doing the same kind of work.	Enter number: The number of full-time employees doing the same type of work.
INJURY INFORMATION	Date of Injury Month	Enter number: The month the loss occurred.
INJURY INFORMATION	Date of Injury Day	Enter number: The day of the month the loss occurred.
INJURY INFORMATION	Date of Injury Year	Enter year: The year the loss occurred.
INJURY INFORMATION	Time of injury AM	Enter time: The approximate time that the loss occurred.
INJURY INFORMATION	Time of injury PM	Enter time: The approximate time that the loss occurred.
INJURY INFORMATION	Last Day Worked Month	Enter number: The month in which the employee last worked.
INJURY INFORMATION	Last Day Worked Day	Enter number: The day of the month the employee last worked.

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INJURY INFORMATION	Last Day Worked Year	Enter year: The year the employee last worked.
INJURY INFORMATION	Date Employer Notified Month	Enter number: The month the employer was notified or became aware of the employee's work related disability/incapacity.
INJURY INFORMATION	Date Employer Notified Day	Enter number: The day of the month the employer was notified or became aware of the employee's work related disability/incapacity.
INJURY INFORMATION	Date Employer Notified Year	Enter year: The year the employer was notified or became aware of the employee's work related disability/incapacity.
INJURY INFORMATION	Date Returned to Work (checkbox)	Check the box (if applicable): Indicates the return to work date is the actual date the employee returned to work.
INJURY INFORMATION	Estimated Date of Return (checkbox)	Check the box (if applicable): Indicates the return to work date is the estimated date the employee will return to work.
INJURY INFORMATION	Month	Enter number: The day the claimant returned/will return to work.
INJURY INFORMATION	Day	Enter number: The month the claimant returned/will return to work.
INJURY INFORMATION	Year	Enter year: The year the claimant returned/will return to work.
INJURY INFORMATION	Was this a lost time or other compensable injury? Yes	Check the box (if applicable): Indicates this is a lost time or compensable injury.
INJURY INFORMATION	Was this a lost time or other compensable injury? No	Check the box (if applicable): Indicates this is not a lost time or compensable injury.
INJURY INFORMATION	Did injury occur as a result of: Substance Abuse	Check the box (if applicable): Indicates the cause of loss is a result of substance abuse.
INJURY INFORMATION	Did injury occur as a result of: Failure to Use Safety Devices	Check the box (if applicable): Indicates the cause of loss is a result of the failure to use safety devices.
INJURY INFORMATION	Did injury occur as a result of: Failure to Obey Rules	Check the box (if applicable): Indicates the cause of loss is a result of the failure to obey rules.
INJURY INFORMATION	Did injury cause death? Yes	Check the box (if applicable): Indicates the incident resulted in a fatality.
INJURY INFORMATION	Did injury cause death? No	Check the box (if applicable): Indicates the incident did not result in a fatality.
INJURY INFORMATION	Date of Death Month	Enter number: The month of the employee's date of death.
INJURY INFORMATION	Date of Death Day	Enter number: The day of the month of the employee's date of death.
INJURY INFORMATION	Date of Death Year	Enter year: The year of the employee's date of death.
INJURY INFORMATION	Name of Closest Dependent of Deceased if injury caused death	Enter text: The full name of the employee's closest dependent.
INJURY INFORMATION	Relationship	Enter code: The relationship of the dependent to the employee. Examples are: I - Insured; S - Spouse; C - Child; SIB - Brother or Sister; P - Parent; E - Employee.
INJURY INFORMATION	Address Line 1	Enter text: The employee's closest dependent's first address line.
INJURY INFORMATION	Address Line 2	Enter text: The employee's closest dependent's second address line.
INJURY INFORMATION	Address Line 3	Enter text: The employee's closest dependent's city name.

<b>Section Name</b>	<b>Field Name</b>	<b>Field and/or Section Description</b>
INJURY INFORMATION		Enter code: The employee's closest dependent's state or province code.
INJURY INFORMATION		Enter code: The employee's closest dependent's postal code.
INJURY INFORMATION	<b>Name of witness</b>	Enter text: The name of a person that was a witness to the incident.
INJURY INFORMATION	<b>Name of Treating Practitioner and Hospital</b>	Enter text: The full name of the physician.
INJURY INFORMATION		Enter text: The name of the hospital.
INJURY INFORMATION	<b>Address of Treating Practitioner and Hospital Line 1</b>	Enter text: The physician's first mailing address line.
INJURY INFORMATION		Enter text: The hospital's mailing address line one.
INJURY INFORMATION	<b>Address of Treating Practitioner and Hospital Line 2</b>	Enter text: The physician's second mailing address line.
INJURY INFORMATION		Enter text: The hospital's mailing address line two.
INJURY INFORMATION	<b>Address of Treating Practitioner and Hospital Line 3</b>	Enter text: The physician's mailing address city name.
INJURY INFORMATION		Enter code: The physician's mailing address state or province code.
INJURY INFORMATION		Enter code: The physician's mailing address postal code.
INJURY INFORMATION		Enter text: The hospital's mailing address city.
INJURY INFORMATION		Enter text: The hospital's mailing address state or province code.
INJURY INFORMATION		Enter text: The hospital's mailing address line postal code.
INJURY INFORMATION	<b>Injury Description</b>	Enter text: The description of how injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill, (e.g., Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal).
INJURY INFORMATION	<b>Report Prepared by</b>	Enter text: The name of the individual that prepared the claim form.
INJURY INFORMATION	<b>Work Phone No.</b>	Enter number: The phone number of the individual that prepared the claim form.
INJURY INFORMATION	<b>Position</b>	Enter text: The title of the individual that prepared the claim form.
INJURY INFORMATION	<b>Date Signed</b>	Enter date: The date the preparer signed the form.
REMARKS	<b>Remarks</b>	Enter text: The workers compensation first report or injury/illness general remarks.
<b>Edition</b>	<b>Date</b>	The edition identifier of the form including the form number and edition (the date is typically formatted YYYY/MM).