

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
Employer's Supplemental Report of Injury

This report, indicating disability of an employee of four or more days, shall be filed as soon as possible after date of knowledge of an occupational injury or disease, but no later than ten days thereafter. Consistent failure to make this report available to the labor commissioner and the nearest claims office of your insurance carrier carries an automatic civil penalty of up to \$100.00. (RSA 281-A:53) This report shall also be submitted upon employee's return to work.

1. Name of Employer _____ Employer's Identification No. _____
(9 digit number assigned by proper Federal Agency)
 2. Address _____
(No. and St.) (City and State) (Zip Code)
 3. Insured by _____
 4. Name of Employee _____
(First Name) (Middle Initial) (Last Name) (S.S. Number)
 5. Address _____
(No. and St.) (City and State) (Zip Code)
 6. Date of injury _____ 19 _____
 7. Date Disability began _____ 19 _____ A.M. _____ P.M. _____
 8. _____
(Specific dates of disability)

(Specific dates of disability)
 9. Has injured returned to work? _____ if so, date and hour _____ A.M. _____ P.M. _____
 10. Is injured person earning same wages as before injury? _____ If not, explain _____

- Date of Report _____

Signed by _____
Official Title _____
Tel. No. _____