

**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 \_\_\_\_\_ 20 \_\_\_\_\_
7. Date Disability began \_\_\_\_\_ 20 \_\_\_\_\_ 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. \_\_\_\_\_