



Employer's First Report of Occupational Injury or Disease (Form 8WC)

Please fill out the information below, then click 'Submit'. Please remember to print a copy for your records after you submit this form; a PDF download will be made available once your report has been submitted.

Please note: As of March 9, 2009 fields in gray boxes are required by Primex3 to assist in data accuracy. Primex3 strives to provide members with the most accurate reports to ensure proper risk management. This additional information will assist us in providing members with detailed, accurate reports.

Denotes a required field.

Employee Information

Name of Injured

First **Middle Initial** **Last**

Date of Birth (MM/DD/YYYY) **Gender** **SSN (###-##-####)**

Address

City/Town **State** **Zip**
NH

Tel. No. **Youth Employment Certificate?**

Department **Occupation when Injured** **Was this his/her Regular Occupation, if not state regular occupation**



Wages per Hour **No. hrs worked per day** **No. days worked per week** **Average Weekly Earnings**

Was Injured hired in NH?

Date Employment Began

Date of Injury **Time of Injury**

Date Disability Began **Was Injured paid in full for this day?**

ate Supervisor/Employer was first notified **Name of Person Notified**

Location/Jobsite where accident occurred **Other Location/Jobsite**

Please enter street address where accident occurred

Other street address

[Text input field]

[Text input field]

Cause of accident

If applicable, select a secondary cause

[Dropdown menu]

[Dropdown menu]

Describe fully how accident occurred and describe what employee was doing when injured. Please DO NOT use actual employee names, refer to as "employee," "subject," "he," "she," etc.

Name of Witness(es)

Part(s) of Body Injured

[Text input field]

[Text input field]

Estimated length of disability [Text input field]

Has injured returned to work? [Dropdown menu]

If yes, what date? [Text input field]

At what occupation or job? [Text input field]

Returned at Full Duty? [Dropdown menu]

Equipment Causing Injury [Text input field]

Were Safeguards in place [Dropdown menu]

/as accident caused by injured's failure to use safeguards or follow regulations [Dropdown menu]

Initial Treatment (Check all those that apply.)

No medical treatment

Care provided by Employer only (on site)

Emergency Care

Hospitalized

Other (Outpatient)

Clinic

Office Visit

Other-Explain [Text input field]

Treating Physician [Text input field]

Treating Hospital [Text input field]

Has Injured Died? [Dropdown menu]

Date of Death [Text input field]

Employer Information

Business Name

CITY OF CLAREMONT [Dropdown menu]

If leased or temporary worker, client's business name

[Text input field]

Employers Federal ID [Text input field]

Business Address [Text input field]

City [Text input field]

State NH [Text input field]

Zip

Tel. No.

Managed Care Program?

If yes, name Provider

Full Time Employees

Part Time Employees

Written Safety Program in Force?

Active Safety Committee?

Business SIC Code

Type or Nature of Business in NH

If report sent by Insurance Agency, state name

Employer Signature

Printed/Typed Name and Official Title

Employee Signature

[Submit](#)

46 Donovan Street • Concord, NH 03301-2624 • (800) 698-2364

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Form 45
Supplemental First Repe



The State of New Hampshire Department of Labor Employer's Supplemental First 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 seven days hereafter. 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 281:46) This report shall also be submitted upon employees return to work.

Please fill out the information below, then click 'Submit'. Please remember to print a copy for your records after you submit this form; a PDF download will be made available once your report has been submitted.

Denotes a required field.

Member

Claimant

Federal Tax ID #

Date Disability began

Time Disability began

Specific dates of Disability

Has Injured returned to work?

Return to Work Date

Return to Work Time

Is injured person earning same wages as before injury?

If not, explain

Submitted by

Official Title

3/17/2016

Employer's Supplemental First Report of Injury

Telephone #

Submit

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Form #4
Supervisor's Investigation

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

Print Form

| | | |
|---|--|---|
| Municipality <input style="width: 95%;" type="text"/> | Department/Division <input style="width: 95%;" type="text"/> | Claim # <input style="width: 95%;" type="text"/> |
| Exact Location Of Incident <input style="width: 95%; height: 30px;" type="text"/> | | Date & Time of Incident <input style="width: 95%; height: 30px;" type="text"/> |
| Name of Witness #1 / Contact Number <input style="width: 95%; height: 30px;" type="text"/> | | Name of Witness # 2 /Contact Number <input style="width: 95%; height: 30px;" type="text"/> |
| Temperature <input style="width: 95%; height: 30px;" type="text"/> | Weather Conditions <input style="width: 95%; height: 30px;" type="text"/> | Light Conditions <input style="width: 95%; height: 30px;" type="text"/> |

Personal Injury or Illness

| | | |
|--|--|--|
| Name <input style="width: 95%;" type="text"/> | Occupation / Job Title <input style="width: 95%;" type="text"/> | Length of Time in Position <input style="width: 95%;" type="text"/> |
| Object / Substance causing injury <input style="width: 95%; height: 40px;" type="text"/> | | |
| Injury / Illness Type <input type="checkbox"/> Abrasion <input type="checkbox"/> Contusion / Bruise <input type="checkbox"/> Burn, Thermal <input type="checkbox"/> Positioning <input type="checkbox"/> Puncture / Laceration <input type="checkbox"/> Sprain / Strain <input type="checkbox"/> Burn, Chemical <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Crushing <input type="checkbox"/> Cumulative Trauma <input type="checkbox"/> Electric Shock / Burn <input type="checkbox"/> Plant /Insect / Animal <input type="checkbox"/> Amputation <input type="checkbox"/> Fracture / Dislocation <input type="checkbox"/> Heat / Cold Stress <input type="checkbox"/> Other <input style="width: 50px;" type="text"/> | | |
| Contributing Acts or Conditions (check all that apply) <input type="checkbox"/> Lifting /material handling <input type="checkbox"/> Sudden movement <input type="checkbox"/> Fatigue /physical condition <input type="checkbox"/> equipment maintenance <input type="checkbox"/> Posture / positioning <input type="checkbox"/> Housekeeping <input type="checkbox"/> Equipment maintenance <input type="checkbox"/> Warnings / labeling <input type="checkbox"/> Equipment selection <input type="checkbox"/> Use of safety features <input type="checkbox"/> Equipment material use <input type="checkbox"/> Proper authorization | | Root Causes & Contributing Factors (check all that apply) <input type="checkbox"/> Knowledge /training <input type="checkbox"/> Equip. specifications <input type="checkbox"/> Selection / placement <input type="checkbox"/> Feedback system <input type="checkbox"/> Supervision <input type="checkbox"/> Policy / practice <input type="checkbox"/> engineering controls <input type="checkbox"/> EE attitude / behavior <input type="checkbox"/> PPE use / condition <input type="checkbox"/> Drug /alcohol /horseplay <input type="checkbox"/> Inspection maintenance <input type="checkbox"/> Environmental conditions |
| <input type="checkbox"/> Personal Protect equip. | <input type="checkbox"/> Other <input style="width: 50px;" type="text"/> | <input type="checkbox"/> Other <input style="width: 50px;" type="text"/> |
| Was Safety equipment & Personal Protective Equipment (PPE) in place and being used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input style="width: 95%; height: 30px;" type="text"/> | | |
| List safety equipment / PPE used and date of last inspection: <input style="width: 95%; height: 40px;" type="text"/> | | |

Property Damage

| | |
|--|--|
| #1 Property Damaged <input style="width: 95%;" type="text"/> | #2 Property Damaged <input style="width: 95%;" type="text"/> |
| Cost <input type="checkbox"/> estimate <input type="checkbox"/> actual \$ <input style="width: 50px;" type="text"/> | Cost <input type="checkbox"/> estimate <input type="checkbox"/> actual \$ <input style="width: 50px;" type="text"/> |
| What action (s) or lack of action(s) contributed to this loss? <input style="width: 95%; height: 40px;" type="text"/> | |

Employee's Description of Incident

| |
|--|
| |
|--|

What could be done to prevent reoccurrence?

| |
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| |
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Employee Name

| |
|--|
| |
|--|

Employee Signature

| |
|--|
| |
|--|

Date

Supervisor's Description of Incident (Clearly relate events leading to incident and attach additional pictures, diagrams etc)

| |
|--|
| |
|--|

Why did this incident happen (List all factors that helped to cause the incident)

| |
|--|
| |
|--|

What could be done to prevent the reoccurrence?

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Date of most recent training relevant to this incident:

| |
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Supervisor Name

| |
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Supervisor Signature

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Date

Safety Committee Review: What could be done to prevent reoccurrence?

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Safety Coordinator Name

| |
|--|
| |
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Safety Coordinator Signature

| |
|--|
| |
|--|

Date

Witness Statement

| | | |
|---|----------------------|----------------------|
| Municipality | Department/Division | Claim # |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Exact Location of Incident | Date of Incident | Time of Incident |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Name | Title | |
| <input type="text"/> | <input type="text"/> | |
| Description of Incident | | |
| <input type="text"/> | | |
| What actions, conditions, or lack of actions contributed to incident? | | |
| <input type="text"/> | | |
| What could be done to prevent reoccurrence? | | |
| <input type="text"/> | | |
| _____ | <input type="text"/> | |
| Witness Signature | Date | |

Distribution

Supervisor - Send completed report to Claims Coordinator
Claims coordinator - Send completed report to 1) Scibal Associates, 2) JA Montgomery Risk Control 3) Safety Coordinator *** Attach Police Report and pictures for all vehicle and property damage reports

Form #5
Vehicle Information Kit

Primex³

RISK MANAGEMENT EXCHANGE
 Transport, Auto and Truck

IS THIS PROPERTY OR FOR DAMAGE TO YOUR VEHICLE?

LOCATION CODE

BODILY INJ.

PROPERTY

DRIVER NAME _____ PHONE _____ DATE OF BIRTH _____

ADDRESS _____ CITY/STATE/ZIP _____ NUMBER OF YEARS WITH _____ DRIVER'S LICENSE NO. _____

VIN # _____ LICENSE NUMBER _____ WHERE VEHICLE CAN BE SEEN _____

Witness Card

Public Risk Management Exchange (Primex³)
 desires that all motor vehicle accidents be reported
 accurately. Your aid to our driver in the performance of
 this duty is appreciated.

Name _____ Zip _____

Phone _____

Street Address _____

City/Town _____

State _____

Did you see the accident? Yes No

Were you involved in the accident? Yes No

Signature _____ Other _____

Supervisor _____

Medical Services

Important
Phone Numbers

Dial **911**
 in New Hampshire for:

- POLICE
- FIRE
- AMBULANCE

Primex³

NH Public Risk Management Exchange

Certificate of Coverage

This vehicle is owned by the public entity shown on the vehicle registration card and coverage is provided by the New Hampshire Public Risk Management Exchange (Primex³).

This Certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend, or alter the coverage afforded by the coverage categories listed below.

Company Affording Coverage:

NH Public Risk Management Exchange (Primex³)
 Bow Brook Place
 46 Donovan Street
 Concord, NH 03301-2624

Type of Coverage
 Auto Member

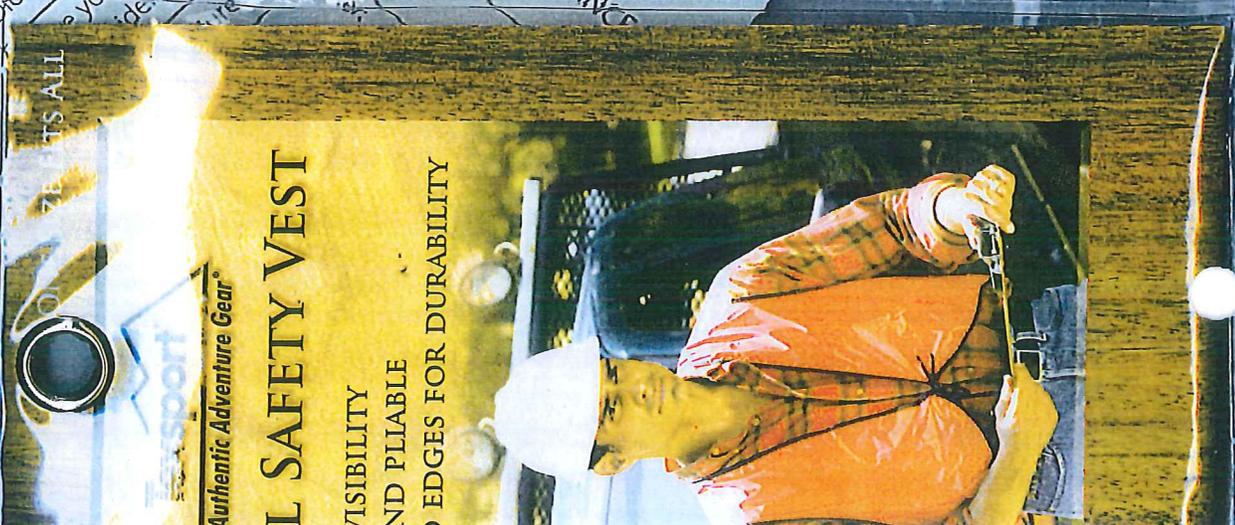
Limits - NH Statutory
 Limits May Apply, If Not:

Comprehensive &
 Collision Coverage
 Deductible \$1,000

Automobile Liability

\$5,000,000 Auto Limit
 Combined Single Limit
 (Each Accident) Aggregate

\$10,000 per accident
 on discretionary basis



INFORMATION KIT
VEHICLE
Primex

Vehicle: _____
VIN Number: _____
Registration: _____

Vehicle Insurance Coverage Information

This vehicle is owned by the public entity shown on the vehicle registration card and insurance coverage is provided by the New Hampshire Public Risk Management Exchange.

In the event of an accident:

1. Stop immediately.
2. Warn oncoming traffic.
3. Check for injuries-if needed call ambulance.
4. Keep calm, make no admissions and take no blame for the accident.
5. Get license numbers and names of persons involved, name(s) of insurance company and policy number of each vehicle involved.
6. Get names and address of any witnesses.
7. Call police and make an accident report at scene.
8. Report accident to your supervisor immediately by phone or in person.
9. Report the claim to:

NH Public Risk Management Exchange
Claims Department
46 Donovan Street
Concord, NH 03301

Tel: 800-698-2364 (in NH) • 603-225-2841

Primex³

RISK MANAGEMENT EXCHANGE
 Report, Auto and Truck

OWNER'S PROPERTY OR FOR DAMAGE TO YOUR VEHICLE

LOCATION CODE
 BODILY INJURY
 PROPERTY DAMAGE

OWNER NAME _____ PHONE _____ DATE OF BIRTH _____
 ADDRESS _____ CITY/STATE/ZIP _____ NUMBER OF YEARS WITH M _____
 VIN # _____ LICENSE NUMBER _____ DRIVER'S LICENSE NO. _____
 WHERE VEHICLE CAN BE SEEN _____

Witness Card

Public Risk Management Exchange (Primex³)
 ensures that all motor vehicle accidents be reported
 accurately. Your aid to our driver in the performance of
 this duty is appreciated.

Name _____ Zip _____
 Phone _____
 Street Address _____
 City/Town _____
 State _____

Did you see the accident? Yes No
 Were you involved in the accident? Yes No
 Name of driver? _____
 Name of Supervisor? _____
 Other? _____

Primex³

NH Public Risk Management Exchange

Certificate of Coverage

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Company Affording Coverage:

NH Public Risk Management Exchange (Primex³)
 Bow Brook Place
 46 Donovan Street
 Concord, NH 03301-2624

Type of Coverage
 Auto Member

Limits - NH Statutory
 Limits May Apply, If Not:

Comprehensive &
 Collision Coverage
 Deductible \$1,000

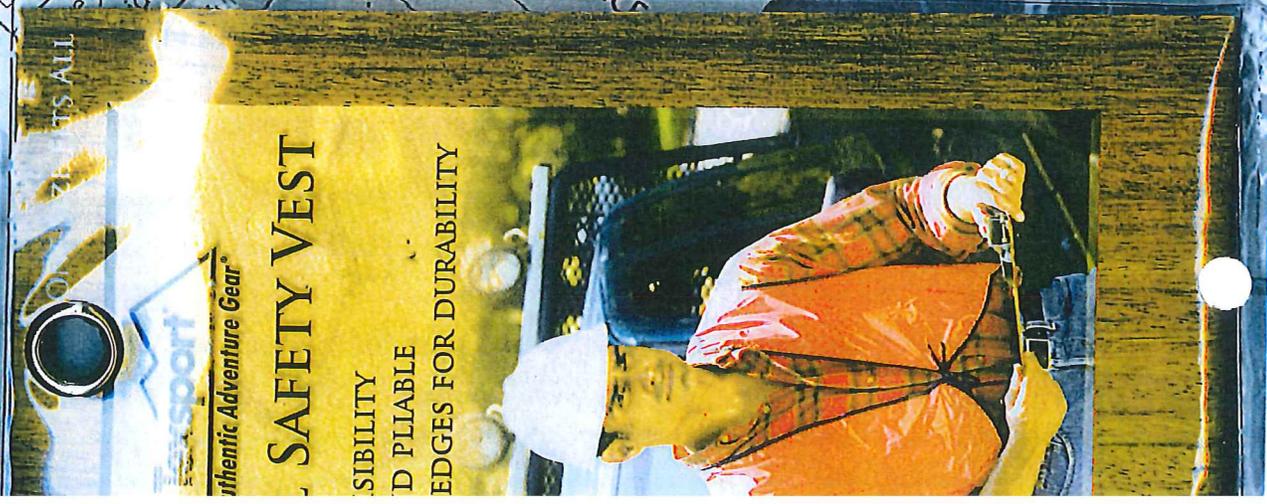
Automobile Liability

\$5,000,000 Auto Limit
 Combined Single Limit
 (Each Accident) Aggregate

\$10,000 per accident
 on discretionary basis

Important
Phone Numbers

Dial **911** in New Hampshire for:
 ■ POLICE
 ■ FIRE
 ■ AMBULANCE



Form #6
Accident Report Vehicle

Immediately after
an accident, fill
out this form.

Primex³

NH PUBLIC RISK MANAGEMENT EXCHANGE

Accident Report, Auto and Truck

LOCATION CODE

- BODILY INJURY
 PROPERTY DAMAGE

(FOR BODILY INJURY OR DAMAGE TO ANOTHER'S PROPERTY OR FOR DAMAGE TO YOUR VEHICLE)

| | | | | | | | | | | | | | | |
|--|--|--------------|-----------------------------|------------------------------|----------------|--|----------------|-------|--------------------------|-----------------------------|--------------------------------|-------|----------|--|
| PRIMEX³ | | | | | | | | | | | | | | |
| MEMBER NAME | | | | | | | | | | | | | | |
| CONTACT NAME | | | PHONE | | DRIVER NAME | | | PHONE | | DATE OF BIRTH | | | | |
| ADDRESS | | | | | ADDRESS | | | | | NUMBER OF YEARS WITH MEMBER | | | | |
| CITY/STATE/ZIP | | | | | CITY/STATE/ZIP | | | | | DRIVER'S LICENSE NO. | | | | |
| VEHICLE | | | | | | | | | | | | | | |
| MAKE OF YOUR VEHICLE | | | YEAR | | MODEL | | VIN # | | LICENSE NUMBER | | WHERE VEHICLE CAN BE SEEN | | | |
| TRAILER (IF APPLICABLE) | | | YEAR | | MODEL | | AREA OF DAMAGE | | | | ESTIMATED COST TO REPAIR \$ | | | |
| ACCIDENT | | | | | | | | | | | | | | |
| DATE OF LOSS | | TIME OF LOSS | | LOCATION (STREET OR HIGHWAY) | | | | | CITY | | STATE | | | |
| WERE POLICE CALLED TO SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | NAME OF POLICE DEPT. CALLED | | | | DRIVER #1 | | TICKETED | | VIOLATION | | ARRESTED | |
| NAME OF OFFICER | | | BADGE NUMBER | | | | DRIVER #2 | | | | | | | |
| ST. ADDRESS | | | | | | | DRIVER #3 | | | | | | | |
| CLAIMANT 1 | | | | | | | | | | | | | | |
| OWNER OF OTHER VEHICLE | | | | AGE | ADDRESS | | | CITY | | STATE | ZIP | PHONE | | |
| DRIVER, IF DIFFERENT THAN ABOVE | | | | AGE | ADDRESS | | | CITY | | STATE | ZIP | PHONE | | |
| MAKE OF VEHICLE | | YEAR | MODEL | LICENSE NO. | | | AREA OF DAMAGE | | ESTIMATE OF DAMAGE \$ | | WHERE CAN VEHICLE BE SEEN | | | |
| CLAIMANT 2 | | | | | | | | | | | | | | |
| OWNER OF OTHER VEHICLE | | | | AGE | ADDRESS | | | CITY | | STATE | ZIP | PHONE | | |
| DRIVER, IF DIFFERENT THAN ABOVE | | | | AGE | ADDRESS | | | CITY | | STATE | ZIP | PHONE | | |
| MAKE OF VEHICLE | | YEAR | MODEL | LICENSE NO. | | | AREA OF DAMAGE | | ESTIMATE OF DAMAGE \$ | | WHERE CAN VEHICLE BE SEEN | | | |
| PROPERTY DAMAGE - OTHER THAN AUTO (E.G. FENCE, CANOPY) | | | | | | | | | | | | | | |
| OWNER OF PROPERTY | | | | ADDRESS | | | | | CITY | | STATE | ZIP | PHONE | |
| DESCRIBE PROPERTY DAMAGE | | | | LOCATION OF PROPERTY | | | | CITY | | STATE | EXTENT OF DAMAGE | | | |
| WITNESS INFORMATION | | | | | | | | | | | | | | |
| NAME | | | ADDRESS | | | | CITY | | STATE | ZIP | PHONE | | | |
| NAME | | | ADDRESS | | | | CITY | | STATE | ZIP | PHONE | | | |

NOTE: PLEASE ALSO COMPLETE THE REVERSE SIDE OF THIS FORM.

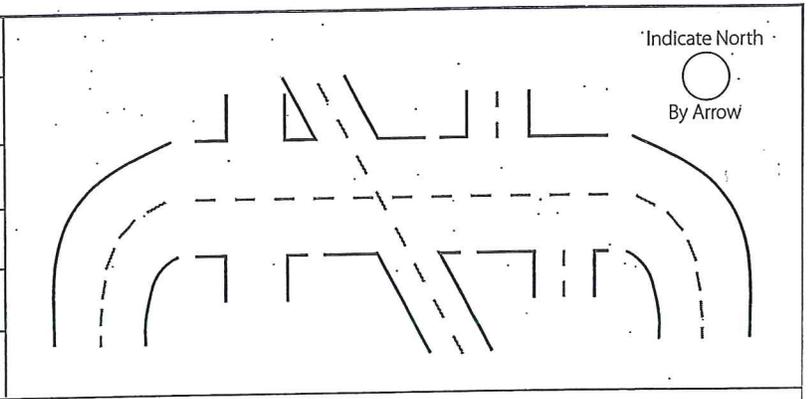
(PERSONS INJURED SHOULD USE ADDITIONAL PAGE IF NECESSARY)

| | | | | | |
|--------------------|-------------|-------|--------------------|-------------|-------|
| NAME | | AGE | NAME | | AGE |
| ADDRESS | | PHONE | ADDRESS | | PHONE |
| CITY / STATE / ZIP | | | CITY / STATE / ZIP | | |
| OCCUPATION | WHERE TAKEN | | OCCUPATION | WHERE TAKEN | |
| NATURE OF INJURIES | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

DESCRIBE ACCIDENT

VEHICLES --- 1 2 --- PEDESTRIAN

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| | | | | | |
|------------------------------|------------------------------|------------------------------|-----------------------------------|--------------------------------|--------------------------------|
| WEATHER CONDITIONS | | | TRAFFIC CONDITIONS | | |
| <input type="checkbox"/> DRY | <input type="checkbox"/> WET | <input type="checkbox"/> ICY | <input type="checkbox"/> FOGGY | <input type="checkbox"/> SNOWY | <input type="checkbox"/> LIGHT |
| | | | <input type="checkbox"/> MODERATE | <input type="checkbox"/> HEAVY | |
| SPEED LIMIT | | ARE YOU FAMILIAR WITH AREA? | | SEAT BELTS WORN? | |
| | | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | |

THIS SECTION MUST BE COMPLETED BY SUPERVISOR

- DO YOU THINK A CLAIM WILL BE MADE AGAINST US/OUR DRIVER? YES NO
- IMPORTANT: HAS THIS ACCIDENT BEEN REPORTED TO PRIME X³? YES NO

IF REPORTED, TO WHOM? _____

DATE: _____

DATE OF REPORT

SIGNATURE AND TITLE