

**ALL COPIES OF THIS FIRST REPORT MUST BE TYPED OR PRINTED**

Department of Labor  
Office of Workers' Compensation (OWC)  
4425 N. Market Street  
Wilmington, DE 19802  
Telephone 302-761-8200

**STATE OF DELAWARE  
FIRST REPORT  
OF OCCUPATIONAL INJURY OR DISEASE**

\_\_\_\_\_  
OWC Case File No.

**ALL INFORMATION IS REQUIRED, unless not applicable where "if applicable" is noted.**

<b>1. EMPLOYEE:</b> FIRST MIDDLE LAST			2. EMPLOYEE SOCIAL SECURITY NO.		
3. ADDRESS - INCLUDE COUNTY AND ZIP CODE			4. MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	5. EMPLOYEE PHONE NUMBER (INCLUDING AREA CODE)	
6. DATE OF BIRTH / /	7. AGE	8. WAGE	9. WEEKLY HOURS WORKED		
10. OCCUPATION (REGULAR)		11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED		12. HOW LONG EMPLOYED	
<b>13. EMPLOYER:</b>			14. PERSON MAKING OUT THIS REPORT		
15. ADDRESS - INCLUDE COUNTY AND ZIP CODE			16. EMPLOYER PHONE # (INCLUDE AREA CODE)		
17. MAILING ADDRESS - IF DIFFERENT THAN ABOVE			18. NATURE OF BUSINESS - TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC.		
19. WORKERS' COMPENSATION INSURANCE CARRIER			20. WORKERS' COMP. INS. CARRIER PHONE #, (INCLUDING AREA CODE)		
21. WORKERS' COMP. INSURANCE CARRIER ADDRESS			22. POLICY NUMBER / CARRIER CASE NUMBER: /		
23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE		24. TPA ADDRESS - INCLUDE CITY STATE AND ZIPCODE			
<b>DATES:</b> 25. DATE OF REPORT / /		26. DATE OF INJURY / /	27. NORMAL STARTING TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	28. IF EMPLOYEE BACK TO WORK GIVE DATE / /	29. AT SAME WAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>
30. IF FATAL INJURY, GIVE DATE OF DEATH / /	31. DATE EMPLOYER KNEW OF INJURY / /	32. DATE DISABILITY BEGAN / /	33. LAST FULL DAY PAID-DATE / /		
<b>INJURY OR DISEASE:</b>					
34. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.					
35. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.					
<b>OCCURRENCE:</b>					
36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.					
37. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, E.G. LIFTING A PATIENT.					
38. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.					
39. NAME OF PHYSICIAN (IF APPLICABLE)			40. PHYSICIAN'S ADDRESS		
41. HOSPITAL (IF APPLICABLE)			42. HOSPITAL ADDRESS		

**DISTRIBUTION OF THIS REPORT (1 original and 3 copies)**

1. ORIGINAL MUST BE SENT IMMEDIATELY TO THE WORKERS' COMPENSATION INSURANCE CARRIER.
2. COPY TO THE OFFICE OF WORKERS' COMPENSATION (use the address at the top left of this form)
3. EMPLOYER'S COPY - RETAIN AS RECORD
4. EMPLOYEE'S COPY

# WORKERS' COMPENSATION

## IMPORTANT THINGS TO DO IN CASE OF INJURY

### ***THE EMPLOYER SHOULD:***

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.
2. Every employer shall keep a record of all injuries received by employees and make a report within 10 days thereof in writing to the Office of Workers' Compensation
3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

### ***THE EMPLOYEE SHOULD:***

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.
2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.

RE: Claim No:  
 Injured Worker:  
 Insured:  
 Date of Injury:

Dear \_\_\_\_\_ :

Please complete the following and return, by fax at 1-800-432-9762 as soon as possible.

Employee's date of hire \_\_\_\_\_  
 Employee's first day out of work \_\_\_\_\_  
 Exact date employee returned to work \_\_\_\_\_  
 Anticipated date of return to work \_\_\_\_\_  
 Wages for 26 weeks prior to accident \_\_\_\_\_

	WEEK ENDING	WAGES		WEEK ENDING	WAGES
1	_____	_____	14	_____	_____
2	_____	_____	15	_____	_____
3	_____	_____	16	_____	_____
4	_____	_____	17	_____	_____
5	_____	_____	18	_____	_____
6	_____	_____	19	_____	_____
7	_____	_____	20	_____	_____
8	_____	_____	21	_____	_____
9	_____	_____	22	_____	_____
10	_____	_____	23	_____	_____
11	_____	_____	24	_____	_____
12	_____	_____	25	_____	_____
13	_____	_____	26	_____	_____

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Account Claims Representative:



DELAWARE WORKERS' COMPENSATION  
 PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY  
**A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER, EMPLOYER AND THE INSURER**

REPORT TYPE                           Initial                                           Progress                                           Closing

WORKER'S NAME \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Employer Name \_\_\_\_\_  
 Employer Phone/Fax \_\_\_\_\_  
 Insurer Name \_\_\_\_\_  
 Insurer Claim No. \_\_\_\_\_  
 Insurer Phone/Fax \_\_\_\_\_

INITIAL VISIT ONLY  
 Injured worker's description of accident/injury \_\_\_\_\_  
 \_\_\_\_\_

WORK RELATED MEDICAL DIAGNOSIS (ES) \_\_\_\_\_  
 \_\_\_\_\_

TREATMENT PLAN:  
 Diagnostic Tests \_\_\_\_\_  
 Procedures \_\_\_\_\_  
 Therapy \_\_\_\_\_  
 Medications \_\_\_\_\_

Hrs. per day patient can work: (circle one)                      8                      6                      4                      2                      0

**D.O.T. Classification of Work** (Circle one)

- Sedentary    Exerting up to 10 lbs. of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.
- Light        Exerting up to 20 lbs. of force occasionally and/or up to 10 lbs. of force frequently and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work.
- Medium     Exerting 20 to 50 lbs. of force occasionally and/or 10 to 25 lbs. of force frequently and or greater than negligible up to 10 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.
- Heavy       Exerting 50 to 100 lbs. of force occasionally and/or 25 to 50 lbs. of force frequently and/or 10 to 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.
- Very Heavy Exerting in excess of 100 lbs. of force occasionally and/or in excess of 50 lbs. of force frequently and/or in excess of 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

**Definitions:**  
**Occasionally:** activity or condition exists up to 1/3 of the time  
**Frequently:** activity or condition exists from 1/3 to 2/3 of the time  
**Constantly:** activity or condition exists 2/3 or more of the time

**Work Postures/Positional tolerances:** Comment **as appropriate** in the space provided regarding the patient's abilities/limitations for the following

Postures/Positions. (e.g. Sitting: No more than 30 minutes continuously)

Sitting: _____	Squatting: _____
Standing: _____	Crawling: _____
Walking: _____	Climbing: _____
Driving: _____	Repeated arm motions: _____
Bending: _____	Repetitive use of wrist/hands: _____
Turn/Twist: _____	Reaching up above shoulder: _____
Kneeling: _____	Foot controls: _____

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Above safe work capacities are:    temporary \_\_\_\_\_    permanent \_\_\_\_\_    anticipate full duty release \_\_\_\_\_  
 Return to work modified duty start date: \_\_\_\_\_

RELEASE TO FULL DUTY WITH NO RESTRICTIONS (Please Circle)    YES (Start date \_\_\_\_\_)    NO

Physician Signature: \_\_\_\_\_                                      Date: \_\_\_\_\_

Physician Name: (Please print) \_\_\_\_\_                                      Certified Provider:: YES    NO

**PHYSICIAN'S FORM  
INSTRUCTIONS/DEFINITIONS**

**The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury. In the event the physician electronically generates this information, the physician's submission is required to contain all information specific to this workers' compensation injury as set forth in the Physician's Form.**

*Complete all applicable fields. Your office notes and records do not replace this form.*

1. **Report Type:** Check "Initial" if this is the first visit related to this described injury. Check "Progress" when there has been any material change in the injured employee's physical capability which impacts the employee's return to work status. Check "Closing" if: injured worker is discharged from care.
  
2. **Case Information:**
  - ◆ **Injured Worker's Name:** Name of the injured worker.
  - ◆ **Date of Birth:** The injured worker's date of birth.
  - ◆ **Date of Injury:** Date of this injury.
  - ◆ **Exam Date:** Date of office visit if applicable.
  - ◆ **Physician's Phone/Fax:** The telephone and fax numbers of the physician completing this form.
  - ◆ **Employer Name:** The name of the employer associated with the claim.
  - ◆ **Employer Phone/Fax:** The telephone and fax numbers of the employer.
  - ◆ **Insurer Name:** The name of the insurance carrier associated with the claim, if known.
  - ◆ **Insurer Claim #:** The claim number assigned by the insurance carrier or self-insured employer, if known.
  - ◆ **Insurer Phone/Fax:** The telephone and fax numbers of the insurance carrier associated with the claim, if known.
  
3. **Initial Visit:** Relate in injured worker's words description of accident/injury.
  
4. **Work Related Medical Diagnosis(es):** State the injured worker's work related medical diagnosis(es).
  
5. **Treatment Plan:** Complete all applicable portions regarding treatment. Indicate frequency and duration.
  - ◆ **Diagnostic tools/tests:** EMG, MRI, CT-scan, etc.
  - ◆ **Procedures:** Any medical procedure including surgical procedures, castings, etc.
  - ◆ **Therapy:** Physical therapy, occupational therapy, home exercise, etc., including plan specifications.
  - ◆ **Medications:** Antibiotics, analgesics, anti-inflammatory drugs, etc.
  - ◆ **Other:** Any treatment not covered above.
  
6. **Hours Per Day Patient Can Work:** Circle the number of hours applicable to this patient.
  
7. **D.O.T. Classification of Work:** Circle the classification of work applicable to this patient.
  
8. **Work Postures/Positional Tolerances:** Comment as appropriate in the space provided regarding the patient's abilities/limitations for the postures/positions listed.
  
9. **Comments:** To be used to explain/clarify any information required by this form.
  
10. **Restrictions:** Check applicable category.
  
11. **Return to Work:** Provide regular duty/modified duty start date.
  
12. **Reevaluation Date:** Provide date of next evaluation.
  
13. **Physician Information:** Type or print the name of the physician and circle "yes" or "no" as to whether the physician is a Certified Provider. The health care provider most responsible for the treatment of the employee's work-related injury must sign and date the report.

**The health care provider most responsible for the treatment of the employee's work-related injury shall complete and submit, as expeditiously as possible and not later than 10 days after the date of first evaluation or treatment, a report of employee condition and limitations, on a form adopted for that purpose pursuant to this section, and shall expeditiously provide copies of the report of employee condition and limitations to the employee, the employer and the employer's insurance carrier, if applicable, as required by 19 Del. C. §2322E(b).**

DELAWARE WORKERS' COMPENSATION  
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

CARRIER/TPA WC #: \_\_\_\_\_ DATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ FAX#: \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_ IS MODIFIED DUTY AVAILABLE: \_\_\_\_ Yes \_\_\_\_ No

IF AVAILABLE, FOR WHAT PERIOD OF TIME: \_\_\_\_ Weeks \_\_\_\_ Indefinite

JOB TITLE: \_\_\_\_\_ JOB DESCRIPTION: \_\_\_\_\_

ENVIRONMENT/WORKING CONDITIONS (e.g., Temperature): \_\_\_\_\_

Hrs. per day job available: (circle minimum and maximum)      8      6      4      2      0

**D.O.T. Classification of Work**      (Circle one)

- Sedentary      Exerting up to 10 lbs. of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.
- Light      Exerting up to 20 lbs. of force occasionally and/or up to 10 lbs. of force frequently and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work.
- Medium      Exerting 20 to 50 lbs. of force occasionally and/or 10 to 25 lbs. of force frequently and or greater than negligible up to 10 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.
- Heavy      Exerting 50 to 100 lbs. of force occasionally and/or 25 to 50 lbs. of force frequently and/or 10 to 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.
- Very Heavy      Exerting in excess of 100 lbs. of force occasionally and/or in excess of 50 lbs. of force frequently and/or in excess of 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

**Definitions:**

- Occasionally:** activity or condition exists up to 1/3 of the time
- Frequently:** activity or condition exists from 1/3 to 2/3 of the time
- Constantly:** activity or condition exists 2/3 or more of the time

Work Postures/Positional requirements: Comment **as appropriate** in the space provided regarding the following Postures/Positions for the modified duty job available.

Sitting: \_\_\_\_\_ Squatting: \_\_\_\_\_ Standing: \_\_\_\_\_  
Crawling: \_\_\_\_\_ Walking: \_\_\_\_\_ Climbing: \_\_\_\_\_  
Driving: \_\_\_\_\_ Repeated arm motions: \_\_\_\_\_ Bending: \_\_\_\_\_  
Turn/Twist: \_\_\_\_\_ Kneeling: \_\_\_\_\_ Foot controls: \_\_\_\_\_  
Reaching up above shoulder: \_\_\_\_\_ Repetitive use of wrist/hands: \_\_\_\_\_

Comments: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Date job is available: \_\_\_\_\_

Comments: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_

PHYSICIAN: I approve the job described above.      ( ) Yes.      ( ) No.

If no, reasons for disapproval/recommended modifications: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name (Please print) \_\_\_\_\_ Certified provider: YES    NO    (Circle)

**The Health Care Provider/Physician MUST complete his/her portion of this form and SIGN and RETURN it to the EMPLOYER within fourteen (14) days of the next date of service after the HC Provider/Physician's receipt of the form from the employer, but not later than twenty-one (21) days from the HC Provider/Physician's receipt of such form.**

## EMPLOYER'S FORM INSTRUCTIONS/DEFINITIONS

The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury.

*Complete all applicable fields.*

### 1. Case Information:

**Employer Name:** The name of the employer associated with the claim.

**Employee Name:** Name of the injured worker.

**Modification Duty Information:** Complete all applicable fields

**Employer Fax:** The telephone and fax numbers of the employer.

**Job Title:** Provide job title for position available.

**Job Description:** Provide description of physical requirements of job duties for position available.

**Environment/Working Conditions:** Identify any environmental factors relevant to position available.

2. **Hours Per Day Job Available:** Circle the number of hours applicable.

3. **Additional Information:** Circle the applicable work status categories for the position available, and comment as appropriate in the space provided regarding the work postures/positional requirements for the modified duty job available.

4. **Employer:** Provide job availability date.

5. **Comments:** To be used to explain/clarify any information required by this form.

6. **Employer Information:** The person responsible for completing this form on behalf of the employer must sign and date this form.

**WITHIN 14 DAYS OF THE ISSUANCE OF AN "AGREEMENT AS TO COMPENSATION" PAYABLE TO AN EMPLOYEE FOR ANY PERIOD OF TOTAL DISABILITY, THE EMPLOYER SHALL PROVIDE THIS FORM TO THE HEALTH CARE PROVIDER/PHYSICIAN MOST RESPONSIBLE FOR THE TREATMENT OF THE EMPLOYEE'S WORK-RELATED INJURY, AND TO THE EMPLOYER'S INSURANCE CARRIER, IF APPLICABLE. THE INSURANCE CARRIER FOR AN INSURED EMPLOYER SHALL SEND TO SUCH EMPLOYER THE AFOREMENTIONED REPORT FOR COMPLETION, AND SHALL BE INDEPENDENTLY RESPONSIBLE FOR PROVIDING A COMPLETED REPORT OF MODIFIED DUTY JOBS TO THE HEALTH CARE PROVIDER/PHYSICIAN, AS REQUIRED BY 19 Del. C. §2322E(d).**

**IF THE "PHYSICIAN'S REPORT OF WORKERS' COMPENSATION INJURY" RELEASES THE EMPLOYEE TO FULL DUTY, DO NOT COMPLETE THIS FORM.**

**THE HEALTH CARE PROVIDER/PHYSICIAN MUST COMPLETE HIS/HER PORTION OF THIS FORM AND SIGN AND RETURN IT TO THE EMPLOYER WITHIN FOURTEEN (14) DAYS OF THE NEXT DATE OF SERVICE AFTER THE PHYSICIAN'S RECEIPT OF THE FORM FROM THE EMPLOYER, BUT NOT LATER THAN TWENTY-ONE (21) DAYS FROM THE PHYSICIAN'S RECEIPT OF SUCH FORM.**



CASE FILE NO. \_\_\_\_\_

CARRIER FILE NO. \_\_\_\_\_

**STATE OF DELAWARE  
OFFICE OF WORKERS' COMPENSATION  
AGREEMENT AS TO COMPENSATION PAID**

---

---

Employee \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Insurance Carrier/Self-insurer \_\_\_\_\_ Third party adjuster \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The above have reached an agreement in regard to compensation for the injury sustained by said employee and submit the following statement of facts relative thereto:

Date of Injury \_\_\_\_\_ Date Disability Began \_\_\_\_\_

Cause/Place of Accident \_\_\_\_\_

Nature/Part of Body \_\_\_\_\_

Probable Length of Disability (if known) \_\_\_\_\_

The terms of this agreement under the above facts are as follows:

This agreement is for (check all that apply) \_\_\_\_\_ Total Disability \_\_\_\_\_ Temporary Partial Disability  
\_\_\_\_\_ Permanent Partial Disability \_\_\_\_\_ Disfigurement \_\_\_\_\_ Commutation \_\_\_\_\_ Medical Only  
\_\_\_\_\_ Salary in Lieu of Workers' Compensation

That the said \_\_\_\_\_ shall receive compensation at the rate of

\$ \_\_\_\_\_ per week based upon an average weekly wage of \$ \_\_\_\_\_ and that said compensation shall be

payable \_\_\_\_\_ weekly \_\_\_\_\_ bi-weekly \_\_\_\_\_ monthly \_\_\_\_\_ other (specify) from and including the \_\_\_\_\_ day of

\_\_\_\_\_ month \_\_\_\_\_ year until terminated in accordance with the provisions of the Workers' Compensation

**BENEFITS FOR TOTAL/PARTIAL DISABILITY, (LOST WAGES) SHALL REQUIRE YOU TO ADVISE THE NAMED CARRIER/SELF-INSURER/THIRD PARTY ADJUSTER OF ANY CHANGES IN EMPLOYMENT STATUS AND/OR DISABILITY. FAILURE TO NOTIFY A CHANGE IN STATUS IS PUNISHABLE PURSUANT TO TITLE 18, DELAWARE CODE, CHAPTER 24, AND/OR TITLE II, DELAWARE CODE, SECTION 913.**

Witness \_\_\_\_\_  
(signature)

Employee \_\_\_\_\_  
(signature)

Address \_\_\_\_\_  
\_\_\_\_\_

Adjuster/Attorney \_\_\_\_\_  
(signature)

Phone number \_\_\_\_\_

Date of agreement \_\_\_\_\_

**PURSUANT TO 19 DEL. C. §2322E(d), THE “EMPLOYER’S MODIFIED DUTY AVAILABILITY REPORT” SHALL ACCOMPANY THIS AGREEMENT AND THE COMPLETED REPORT SHALL BE FORWARDED TO THE HEALTHCARE PROVIDER/PHYSICIAN MOST RESPONSIBLE FOR TREATMENT WITHIN 14 DAYS. THE INSURANCE CARRIER FOR AN INSURED EMPLOYER SHALL BE INDEPENDENTLY RESPONSIBLE FOR PROVIDING A COMPLETED REPORT OF MODIFIED-DUTY JOBS TO THE PROVIDER/PHYSICIAN.**

For Accounting Use Only:

Approved by \_\_\_\_\_

Date of Approval \_\_\_\_\_



CASE FILE NO. \_\_\_\_\_

CARRIER FILE NO. \_\_\_\_\_

STATE OF DELAWARE  
OFFICE OF WORKERS' COMPENSATION  
RECEIPT OF COMPENSATION PAID

DATE \_\_\_\_\_

Received of \_\_\_\_\_  
(Insurance Carrier/Self-Insurer/Third Party Adjuster)

the sum of \$ \_\_\_\_\_, making in all the total sum of \$ \_\_\_\_\_

in settlement of compensation due for the \_\_\_\_\_ disability of  
(type)

\_\_\_\_\_ which began  
(employee name)

on \_\_\_\_\_, and terminated on \_\_\_\_\_.  
(date) (date)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Address

Your signature on this receipt will terminate your rights to receive the worker's compensation benefits specified above on the date indicated. This form is not a release of the employer's or the insurance carrier's workers' compensation liability. It is merely a receipt of compensation paid. The claimant has the right within five years after the date of the last payment to petition the Office of Workers' Compensation for additional benefits.





**STATE OF DELAWARE - 7621402  
INDEMNITY PAYMENTS**

HR DEPT. HERMAN HOLLOWAY CAMPUS  
1901 N. DUPONT HIGHWAY  
MAIN BUILDING, 2ND FLOOR  
NEW CASTLE DE 19720

REPORT PERIOD: CHECKS ISSUED 05/01/15 AND PRIOR TO 05/15/15

LOCATION 0035-06-30 - DE PSYCHIATRIC CENTER

Claim Number	Injured Worker	Accident Date	Disability Start Date	Pay Start Date	Pay End Date	Check Issue Date	Transaction Number	Payment Amount
W000278092		06/21/11	06/22/11	04/20/15	05/03/15	05/01/15	C103030921	625.42
W001412569		03/26/15	03/27/15	04/24/15	05/07/15	05/05/15	C103072856	929.54
W001335665		12/02/14	12/03/14	04/20/15	05/19/15	05/12/15	C103083702	760.80
W000019436		07/21/10	07/21/10	04/24/15	05/07/15	05/06/15	C103025532	680.00
W880762331		12/16/07	05/30/08	04/28/15	05/11/15	05/07/15	C102999976	1,184.50
W000079737		09/15/10	09/16/10	05/02/15	05/15/15	05/14/15	C103018136	699.52
W881036844		06/15/10	06/15/10	04/24/15	05/07/15	05/05/15	C102981844	204.00
W881019049		03/28/10	03/28/10	04/20/15	05/03/15	05/01/15	C102926808	833.08
W000506844		04/25/12	04/26/12	04/25/15	05/08/15	05/06/15	C102962475	270.00
W708890011		02/12/88	02/27/88	05/01/15	05/14/15	05/13/15	C103039273	467.60
W000612670		10/07/12	10/08/12	05/05/15	05/18/15	05/14/15	C103041304	835.82
W880977410		12/31/09	12/31/09	04/30/15	05/13/15	05/12/15	C103034890	838.90
W880625580		06/27/06	06/28/06	05/05/15	05/18/15	05/14/15	C103087249	708.86
W001071327		12/31/13	01/01/14	04/30/15	05/13/15	05/12/15	C103078968	1,233.84
<b>Total Number of Claims 14</b>								<b>10,271.88</b>





STATE OF DELAWARE  
DEPARTMENT OF LABOR  
DIVISION OF INDUSTRIAL AFFAIRS  
4425 NORTH MARKET STREET  
WILMINGTON, DELAWARE 19802

TELEPHONE (302)761-8200  
FAX (302)736-9170

*Winner, Delaware Quality Award of Merit*

## MEMORANDUM

### NEW WORKERS' COMPENSATION RATE EFFECTIVE JULY 1, 2015

Secretary of Labor John J. McMahon, Jr. has announced that the average weekly wage in Delaware for calendar year 2014 was \$1,019.44. This wage figure was derived from data from employers participating in the State's unemployment insurance system.

Based on this weekly wage figure, the maximum weekly workers' compensation rate will be \$679.63. The minimum workers' compensation rate will be \$226.54. The daily rates are as follows:

Effective July 1, 2015

Wage of \$1,019.44 and Over:	Maximum	\$679.63
1		97.09
2		194.18
3		291.27
4		388.36
5		485.45
6		582.54
7		679.63
	Minimum	\$226.54

## STATE OF DELAWARE WORKERS' COMPENSATION RATE CHART

<u>EFFECTIVE JUNE 1, 1977</u>		<u>EFFECTIVE JULY 1, 1990</u>		<u>EFFECTIVE JUNE 4, 2003</u>	
AWW \$215.99	\$144.00	AWW \$445.81	\$297.21	AWW \$760.21	\$506.81
Minimum	\$ 48.00	Minimum	\$ 99.07	Minimum	\$168.94
<u>EFFECTIVE JUNE 15, 1978</u>		<u>EFFECTIVE JULY 1, 1991</u>		<u>EFFECTIVE MAY 21, 2004</u>	
AWW \$221.75	\$154.50	AWW \$468.58	\$312.39	AWW \$785.75	\$523.83
Minimum	\$ 51.49	Minimum	\$104.13	Minimum	\$174.61
<u>EFFECTIVE June 20, 1979</u>		<u>EFFECTIVE JULY 1, 1992</u>		<u>EFFECTIVE JUNE 6, 2005</u>	
AWW \$247.07	\$164.71	AWW \$491.75	\$327.83	AWW \$815.29	\$543.53
Minimum	\$ 54.90	Minimum	\$109.28	Minimum	\$181.18
<u>EFFECTIVE MAY 23, 1980</u>		<u>EFFECTIVE JULY 1, 1993</u>		<u>EFFECTIVE JUNE 7, 2006</u>	
AWW \$262.79	\$175.20	AWW \$508.94	\$339.29	AWW \$857.46	\$571.64
Minimum	\$ 58.40	Minimum	\$113.10	Minimum	\$190.55
<u>EFFECTIVE JUNE 1, 1981</u>		<u>EFFECTIVE JUNE 14, 1994</u>		<u>EFFECTIVE JUNE 7, 2007</u>	
AWW \$292.20	\$194.81	AWW \$519.25	\$346.17	AWW \$888.38	\$592.25
Minimum	\$ 64.94	Minimum	\$115.39	Minimum	\$197.42
<u>EFFECTIVE JUNE 1, 1982</u>		<u>EFFECTIVE JUNE 15, 1995</u>		<u>EFFECTIVE JUNE 3, 2008</u>	
AWW \$312.66	\$208.45	AWW \$535.79	\$357.10	AWW \$907.73	\$605.15
Minimum	\$ 69.47	Minimum	\$119.06	Minimum	\$201.72
<u>EFFECTIVE JUNE 7, 1983</u>		<u>EFFECTIVE JUNE 3, 1996</u>		<u>EFFECTIVE JUNE 16, 2009</u>	
AWW \$335.66	\$223.78	AWW \$558.35	\$372.23	AWW \$916.00	\$610.67
Minimum	\$ 74.59	Minimum	\$124.08	Minimum	\$203.55
<u>EFFECTIVE JUNE 15, 1984</u>		<u>EFFECTIVE JUNE 18, 1997</u>		<u>EFFECTIVE JUNE 22, 2010</u>	
AWW \$347.45	\$231.64	AWW \$588.69	\$392.46	AWW \$914.73	\$609.82
Minimum	\$ 77.22	Minimum	\$130.82	Minimum	\$203.27
<u>EFFECTIVE JUNE 3, 1985</u>		<u>EFFECTIVE JUNE 11, 1998</u>		<u>EFFECTIVE JUNE 13, 2011</u>	
AWW \$353.53	\$235.69	AWW \$616.67	\$411.11	AWW \$933.08	\$622.05
Minimum	\$ 78.56	Minimum	\$137.04	Minimum	\$207.35
<u>EFFECTIVE JUNE 5, 1986</u>		<u>EFFECTIVE JUNE 15, 1999</u>		<u>EFFECTIVE JULY 2, 2012</u>	
AWW \$366.33	\$244.22	AWW \$652.02	\$434.68	AWW \$967.52	\$645.01
Minimum	\$ 81.41	Minimum	\$144.89	Minimum	\$215.00
<u>EFFECTIVE JULY 1, 1987</u>		<u>EFFECTIVE JUNE 12, 2000</u>		<u>EFFECTIVE JULY 1, 2013</u>	
AWW \$375.79	\$250.53	AWW \$674.40	\$449.60	AWW \$991.19	\$660.79
Minimum	\$ 83.51	Minimum	\$149.87	Minimum	\$220.26
<u>EFFECTIVE JULY 1, 1988</u>		<u>EFFECTIVE JUNE 20, 2001</u>		<u>EFFECTIVE JULY 1, 2014</u>	
AWW \$397.71	\$265.14	AWW \$703.65	\$469.10	AWW \$998.35	\$665.57
Minimum	\$ 88.38	Minimum	\$156.37	Minimum	\$221.86
<u>EFFECTIVE JULY 1, 1989</u>		<u>EFFECTIVE JUNE 14, 2002</u>		<u>EFFECTIVE JULY 1, 2015</u>	
AWW \$420.96	\$280.64	AWW \$737.35	\$491.57	AWW \$1,019.44	\$679.63
Minimum	\$ 93.55	Minimum	\$163.86	Minimum	\$226.54

AWW- Average Weekly Wage



STATE OF DELAWARE  
EXECUTIVE DEPARTMENT  
OFFICE OF MANAGEMENT AND BUDGET

# MEMO

**Date:** May 1, 2007

**To:** Personnel Administrators, Officers & Representatives, School Districts, Department of Public Education, Delaware State University, Delaware Technical & Community College, University of Delaware and Port of Wilmington

**From:** Debra Lawhead, AIC, CPIW, Insurance Coverage Administrator *DLW*

**RE:** Salary Supplement Application

---

There have been a number of questions on the application of the salary supplemental pay statute.

A review of the application of the supplemental pay statute, 29 *Del. C.* § 5933(d) in light of a recent amendment enacted as part of the 2005 general appropriation bill, 75 *Del. Laws c.* 89, § 30 has been completed. Two questions were asked: (1) Does the 2005 amendment limit an injured State employee to receipt of the state supplemental pay for one 90 day period from the date of qualification for worker's compensation benefits? The answer to this question is in the affirmative based on the limiting language in the new provision to the statute. (2) A related question is whether a State employee can only receive the state supplemental benefit for consecutive days while receiving worker's compensation benefits? The answer to this question appears to be no based on the plain wording of the statute which contains no requirement that the state salary benefit be received during only one period of consecutive days.

To further clarify these issues, I have included a couple of scenarios based on the application of the code and legislative amendment.

First scenario: Date of loss: 4-1-07. Employee is out of work for 14 days. Returns back to work for 2 weeks and goes out again for 20 days. The first period of time (14 days) is covered by the salary supplement. The second period of 20 days is also covered because it is within the 90 day period established by the date compensation began. In other words, any lost time from work that is



Page 2  
Salary Supplement Application

covered by workers' compensation within that 90 day period (April, May and June) would qualify that employee to receive salary supplement.

Second scenario: Date of loss: 4-1-07. Employee is out of work for 14 days. Returns back to work. The employee then goes out for surgery on July 1<sup>st</sup>. In this scenario the first period of time (14 days) is covered by the salary supplement. The second period of time which begins on July 1<sup>st</sup> would not be covered since it is beyond the 90 day period (April, May & June) established by the first date compensation began.

Third scenario: Same as First scenario but the employee goes out again on June 15<sup>th</sup> and remains out until September 1<sup>st</sup>. First period 14 days covered by salary supplement. Second period of 20 days is covered by salary supplement. Third period the salary supplement would end on June 30<sup>th</sup>.

**STATE OF DELAWARE  
INSURANCE COVERAGE OFFICE**

500 W. Loockerman Street  
Suite 300

Dover, DE 19904

Toll Free: (877) 277-4185

Phone: (302) 739-3651  
<http://inscov.delaware.gov>

Fax: (302) 739-5345  
Email: [inscov@state.de.us](mailto:inscov@state.de.us)

## Automobile Accident Report

INSURED	State Agency	If Other			
	Address	Phone #			
	City	State	Zip		
TIME & PLACE OF ACCIDENT	Date	Time	<input type="radio"/> AM	<input type="radio"/> PM	
	Location				
	City	State			
STATE OWNED VEHICLE (# 1)	Make & Model	Year	VIN #	Tag No.	
	Driver		Empl Id.		
	Address			Home Phone No.	
	City	State		Zip	
	Age	Years Licensed	Employed By		
	For what purpose was vehicle being used?				
	Owner				
DAMAGE TO STATE OWNED VEHICLE (# 1)	Describe Damage				
	Est. cost of repairs \$		Where vehicle may be seen		
	Make & Model	Tag No.	Year		
OTHER VEHICLE (# 2)	Owner's Name			Phone #	
	Owner's Address				
	City	State	Zip		
	Driver's Name			Phone #	
	Driver's Address				
	City	State	Zip		
	Insurance Carrier	Policy #			
DAMAGE TO OTHER VEHICLE (# 2)	Describe Damage				
	Est. cost of repairs \$		Where vehicle may be seen		
	Describe Damage				
OTHER PROPERTY DAMAGE	Owner			Address	
	Est. cost of repairs \$		Where damaged property may be seen		
	Describe Damage				
YOUR PASSENGERS	NAME		AGE	ADDRESS	
	1				
	2				
	3				
	4				
WITNESSES (not involved in accident)	NAME		AGE	ADDRESS	
	1				
	2				
	3				
	4				
INJURED PERSONS	NAME		AGE	ADDRESS	
	1				
	2				
	3				
	4				
EXTENT OF INJURIES	1				
	2				
	3				
	4				

ACCIDENT FACTS	Direction of Your Vehicle	on	<input type="radio"/> Street	<input type="radio"/> Highway	
	Rate of Speed	MPH	What side of street?		
	Direction of Other Vehicle	on	<input type="radio"/> Street	<input type="radio"/> Highway	
	Rate of Speed	MPH	What side of street?		
	Width of street	Nature and condition of pavement			
	Weather				
	Was there a police investigation?		Complaint #		
Which Dept		If Other			
STATEMENT OF DRIVER					
Driver's Name		Home Address			
Driver's Signature _____					
Date of this Report 8/14/15					
Supervisor Name		Phone #			
Contact Person		Phone #			
Completed By		Phone #			
VEHICLE OTHER (# 3)	Make & Model	Tag No.	Year		
	Owner's Name	Phone #			
	Owner's Address				
	City	State	Zip		
	Driver's Name	Phone #			
	Driver's Address				
	City	State	Zip		
DAMAGE TO OTHER VEHICLE (# 3)	Insurance Carrier	Policy #			
	Describe Damage				
	Est. cost of repairs \$	Where vehicle may be seen			
OTHER VEHICLE (# 4)	Make & Model	Tag No.	Year		
	Owner's Name	Phone #			
	Owner's Address				
	City	State	Zip		
	Driver's Name	Phone #			
	Driver's Address				
	City	State	Zip		
DAMAGE TO OTHER VEHICLE (# 4)	Insurance Carrier	Policy #			
	Describe Damage				
	Est. cost of repairs \$	Where vehicle may be seen			
<div style="border: 1px solid black; padding: 5px; display: inline-block;">Submit by Email</div>					

**COMPANY: STATE OF DELAWARE - INSURANCE COVERAGE OFFICE**

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER
------	------------------	------------------	-------------

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE DELAWARE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

TO: \_\_\_\_\_

FOLD HERE

YOUR NAME	PHONE NUMBER - HOME	PHONE NUMBER - BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODES)	DATE OF BIRTH	SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
---	--

**BRIEF DESCRIPTION OF ACCIDENT**

---



---

AT THE TIME OF ACCIDENT:	WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	WERE YOU A PEDESTRIAN?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES  NO  IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DESCRIBE YOUR INJURY

---

WERE YOU TREATED BY A DOCTOR YES <input type="checkbox"/> NO <input type="checkbox"/>	DOCTOR'S NAME AND ADDRESS
--	---------------------------

IF YOU WERE TREATED IN A HOSPITAL IN-PATIENT <input type="checkbox"/> OUT-PATIENT <input type="checkbox"/>	WERE YOU AN	HOSPITAL'S NAME AND ADDRESS
---	-------------	-----------------------------

AMOUNT OF MEDICAL BILLS TO DATE \$	WILL YOU HAVE MORE MEDICAL EXPENSES? YES <input type="checkbox"/> NO <input type="checkbox"/>	AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------------------	--	---

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, AMOUNT LOST TO DATE \$	WHAT IS YOUR AVERAGE NET? WEEKLY WAGE OF SALARY \$
--	--------------------------------	---

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK
--	---------------------------

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WAGE OR SALARY CONTINUATION PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, AMOUNT \$	PER WEEK <input type="checkbox"/>	PER MONTH <input type="checkbox"/>
--	-------------------	-----------------------------------	------------------------------------

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES  NO  IF YES, EXPLAIN ON REVERSE SIDE.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**IMPORTANT:**

1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATIONS.
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.



**DO NOT DETACH**

**AUTHORIZATION FOR MEDICAL INFORMATION**

**THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE DELAWARE PERSONAL INJURY PROTECTION BENEFITS LAW.**

---

*SIGNATURE*

*DATE*

**DO NOT DETACH**

**AUTHORIZATION FOR WAGE AND SALARY INFORMATION**

**THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE DELAWARE PERSONAL INJURY PROTECTION BENEFITS LAW.**

---

*SIGNATURE*

*DATE*

*SOCIAL SECURITY NUMBER*

