WCC CASE NO.:

FORM WC-E1

EMPLOYER RESPONSE ON FILED CLAIM BEFORE THE WCC

Instructions: Upon receiving the official notice of a claim filed by an injured employee, the employer is directed to provide a respond on the filed claim to the Commission. The employer must complete and submit this form within 14-calendar days upon receipt of the claim notice to the Commission's Office, as well as the submission of all documentations as required by this form. If an attorney is involved or retained, the employer is fully advice to collaborate with the attorney in completing this form.

1. **Date of this Report:**
2. **Date of Injury:**
3. **Employee's Name:**
4. **Employee's Occupation:**
5. **Employer's Name:**
6. **Employer's WC Insurance Carrier:**
7. **Date Employee was Hired by the Employer:**
8. **Date – Employer's First-Knowledge of the Injury:**
9. **As required by law, did the employer filed an injury report with the Commission?**
   ☐ **Yes – Date of Report:** ______________________. | ☐ **No**
10. **Did the employer provided the proper equipment, tools, and safety gear and other related safety apparel for the employee to perform his or her job on the date of injury?**
    ☐ Yes | ☐ No | ☐ Employee did not use it
    ☐ Not applicable – specify reason why:
11. **Is the employee injury caused by defective tools, equipment, or supplies?**
    ☐ Yes | ☐ No
12. **Was the employee intoxicated during date of injury?**
    ☐ Yes | ☐ No
13. **Did employee showed intent to injured him or herself?**
    ☐ Yes | ☐No
14. **Were there any other employees injured from the same accident?**
    ☐ Yes – how many? ____________ | ☐ No
15. **Has employee been terminated from employment due to the work injury?**
    ☐ Terminated | ☐ Demoted | ☐ No
16. **Date employee officially stopped working:**
17. **Has Employee returned to work?**
    ☐ Yes | ☐ No
18. **Date employee returned to work – if applicable:**
19. **Have Employee leave hours exhausted?**
    ☐ Yes | ☐ No
    ☐ Not Applicable
20. **Total leave hours used due to injury:**
    Sick: _________ | Annual: _________
21. **Total Unpaid or LWOP hours incurred due to work injury – if any:**
    Leave Without Pay (LWOP): _____________
    Dated From: __________________ to: ___________________
22. **Employee's Hourly Rate:**
23. **Employee's Total Wage or Salary:**
    $________________________: ☐ Weekly | ☐ Annual
24. **Has employee's salary or wages demoted due to the injury?**
    ☐ Yes | ☐ No
25. **Have employee submitted an injury report?**
    ☐ Yes – Date of Report: _________________ | ☐ No
26. **Did Employer know or fully aware of the employee having pre-existing medical conditions or disability during hiring?**
    ☐ Yes | ☐ No
27. **Verify which of the following actions made by the employer on the date of injury:**
    ☐ Employee treated on site and taken to the hospital
    ☐ Employee treated on site but continued on working and not taken to hospital
    ☐ Employee treated on site and sent home but not the hospital
    ☐ Employee was injured elsewhere and transported directly to the hospital
28. **In regards to the employee claim filed before the Commission, does the employer contest and dispute claim filed by the Injured Employee?**
    ☐ NO – the Employer acknowledges that the injury as filed and reported is work-related;
    ☐ YES – the Employer contests and controverts right to compensation due to injury not work-related or reasons warranted by provisions of the American Samoa Workmen's Compensation Act. (*** Important Note: If a claim is disputed and controvert, a FORM PER-37: NOTICE TO CONTROVER CLAIM must be filed with the Commissioner within 14-days after the employer has knowledge of the alleged injury, or upon receipt of claim notice. Please make sure to furnish and provide a FORM PER-37 with this form.
29. **Name of Person Signing this Report:**
30. **Position or Title of Person Signing this Report:**
31. **Authorized Signature:**
    X____.

FILED
*** AUTHORIZED OWCC PERONNEL ONLY ***

FORM DISTRIBUTION:

Original – Commission | Copy – Employer | Copy - Carrier