Please complete all date fields with the MM/DD/YYYY format.

Print | Reset Form

Fill-In Instructions

EMPLOYEE'S REPORT OF CLAIM

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
P. O. Box 30016, Lansing, MI 48909

1. Social Security Number	2. Date of Injury		3. Date of Birth (MM/DD/YYYY)	4. Employee's Telephone Number ( )	
5. Employee Name (Last, First, MI)			6. Employer Name		
7. Employee Street Address			8. Employer Street Address		
9. City	10. State	11. ZIP Code	12. City	13. State	14. ZIP Code

15. Describe the type of injury and explain how it happened. (If a medical report is available, please attach a copy)

16. Are you making a claim for payment of medical expenses? ☐ Yes ☐ No If yes, please attach a copy of medical bill(s) if available.	17. Last Day Worked
18. Have you gone back to work? ☐ Yes ☐ No If yes, date of return. _____ | _____ | _____	19. Was injury reported to your employer? ☐ Yes ☐ No If yes, what date was it reported? _____ | _____ | _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.	Authority: Workers' Disability Compensation Act, 408.31(4) Completion: Voluntary Penalty: None

20. Employee Signature	21. Date of this report

OFFICE USE ONLY

Carrier Name	NAIC Number	Federal I.D. Number

The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

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Form #	**BWC-117**	**Form Name:**	**Employee's Report of Claim**

Required Fields: All applicable fields must be completed.

Instructions:

Completing the Form:

- **U** Select the hand tool from the Acrobat toolbar menu. You can use the hand tool to move the page around so that you can view all areas.
- **U** Position the hand pointer inside a form field and click. The I-beam pointer allows you to type text.
- **U** To complete the "red boxes," using your mouse, position the cursor over the applicable box until the pointing finger icon appears and click.
- **U** Press Tab to accept the field change and go to the next field, or
  Press Shift + Tab to accept the field change and go to the previous field.
- **U** Use your mouse to select an area of the form that is not inside a form field before printing your form.
- **U** To print, be sure to use the printer button on the Acrobat toolbar menu to print the form instead of your web browser's print function. You may need to select the "Print as image" option in the print dialog box to print the completed form.
- **U** To print the completed form only, select "Print Current Page" or "Pages From: 1 To: 1"

NOTE: Please complete all date fields with the **MM/DD/YYYY** format.

If you have any comments on this fill-inform, please send them to bwdcinfo@cis.state.mi.us. Please include the keyword "Fill-In Form 117" with your comments.

How to Submit This Form:

- **U** Print 2 copies of the completed form
- **U** Sign
- **U** Keep a copy for your records
- **U** Mail a signed copy of the Form 117 to:

Bureau of Workers' Disability Compensation
P O Box 30016
Lansing MI 48909