STATE OF DELAWARE FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

Department of Labor
Office of Workers' Compensation (OWC)
4425 N. Market Street
Wilmington, DE 19802
Telephone 302-761-8200
OWC Case File No.

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

I.EMPLOYEE: FIRST MIDDLE LAST								2. EMPLOYEE SOCIAL SECURITY NO.					
3. ADDRESS – INCLUDE COUNTY AND ZIP CODE						4. MALE			4. EMPLOYEE PHONE NUMBER				
						FEMALE (INCLUDING AREA COL					AREA CODE)		
						UNSPEC	IFIED)					
6. DATE OF BIRTH	7.AGE 8. WAGE							9. WEEKLY HOURS WORKED					
10. OCCUPATION (BECULAR)						ION REGULARLY EMPLOYED				12 HOW LONG FMPLOVED			
10. OCCUPATION (REGULAI	()		II. DEPARTN	MENT OR	DIVISIO	ON REGULARLI EMPLOTED			YED	12. HOW LONG EMPLOTED			
13. EMPLOYER: 13. PERSON MAKING OUT THIS REPORT													
15. ADDRESS - INCLUDE COUNTY AND ZIP CODE						16. EMPLOYER PHONE# (INCLUDE AREA CODE)							
17. MAILING ADDRESS-IF D	IFFERENT THA	AN AE	OVE								OF MFG., T	TRADE,	
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/ CARRIER NUMBER/									ER CASE NUMBER:				
23. THIRD PARTY ADMINISTRATOR (TPA), IF APPLICABLE 24. TPA ADDRESS- INCLUDE CITY STATE AND ZIPCODE													
DATES: 25. DATE OF REPORT	, ,					ARTING TIME WORK GIVE DA			ORK GIVE DAT	TE 29. AT SAME WAGE?			
30. IF FATAL INJURY, GIVE	•	'H	31. DATE EMP	LOYER I	AM KNEW O	PM F INJURY	32	2. DATE	DISABILITY BE	EGAN	33. LAST		
1 1			1	ı				I	I			1 1	
INJURY OR DISEASI 34. DESCRIBE THE INJURY/I	LLNESS AND P												
35. SPECIFY THE DEPARTMI	ENT WHERE IN	CIDE	NT OCCURRED	AND TH	E WORK	X PROCESS	INVO	LVED.					
OCCURRENCE: 36. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE USED WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.													
37. DESCRIBE THE EMPLOY	EE'S ACTIVITY	AT T	HE TIME OF IN	JURY OF	R ILLNE	SS, E.G. LIF	TING	A PATIE	ENT.				
38. DESCRIBE HOW THE INJ	URY/ILLNESS	OCCUI	RRED.					4. EMPLOYEE PHONE NUMBER (INCLUDING AREA CODE)					
39. NAME OF PHYSICIAN (IF APPLICABLE) 40. PHYSICIAN'S ADDRESS													
41. HOSPITAL (IF APPLICAB	LE)			42. HO	OSPITAI	L 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.