



# WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER / ADMINISTRATOR CLAIM NUMBER *		REPORT PURPOSE CODE *	
		JURISDICTION *	JURISDICTION LOG NUMBER *		
		INSURED REPORT NUMBER		OSHA CASE NUMBER	
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #:
INDUSTRY CODE	EMPLOYER FEIN			PHONE #	

## CARRIER / CLAIMS ADMINISTRATOR

CARRIER (NAME AND ADDRESS)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME AND ADDRESS)	
PHONE (A/C, No, Ext):		CHECK IF APPROPRIATE	PHONE (A/C, No, Ext):	
CARRIER FEIN *	POLICY / SELF-INSURED NUMBER	SELF INSURANCE	ADMINISTRATOR FEIN *	
AGENT NAME:		AGENT CODE NUMBER:		

## EMPLOYEE / WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION / JOB TITLE	
E-MAIL ADDRESS:		# OF DEPENDENTS	EMPLOYMENT STATUS		
PHONE		NCCI CLASS CODE *			
RATE PER:	DAY WEEK	MONTH OTHER:	AVERAGE WEEKLY WAGES	# DAYS WORKED / WEEK	FULL PAY FOR DAY OF INJURY? (Y / N) DID SALARY CONTINUE? (Y / N)

## OCCURRENCE / TREATMENT

TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE CANNOT BE DETERMINED	AM PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME		TYPE OF INJURY / ILLNESS			PART OF BODY AFFECTED		
PHONE (A/C, No, Ext):		TYPE OF INJURY / ILLNESS CODE *			PART OF BODY AFFECTED CODE *		
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? (Y / N) <input type="checkbox"/>		DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED			ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED		
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL							CAUSE OF INJURY CODE *
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? (Y / N) WERE THEY USED? (Y / N)				
PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFFSITE TREATMENT (NAME & ADDRESS)			INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC / HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> OVERNIGHT HOSPITALIZATION <input type="checkbox"/> FUTURE MAJOR MEDICAL / LOST TIME ANTICIPATED		
WITNESS NAME:		WITNESS NAME:					
PHONE (A/C, No, Ext):		PHONE (A/C, No, Ext):					
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER			