

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

DIVISION OF LABOR AND MANAGEMENT

Tel: 605.773.3681 dlr.sd.gov

FIRST REPORT OF INJURY

GENERAL INSTRUCTIONS

EMPLOYEE

1. Notify employer immediately of injury, as required by SDCL 62-7-10.
2. Complete all questions in the EMPLOYEE and INJURY/TREATMENT sections.
3. Sign the form.
4. Submit this form to your employer within three (3) business days after the injury.

EMPLOYER

1. Complete all questions in the EMPLOYER/EMPLOYMENT sections.
2. Sign the form.
3. Submit this form to your workers' compensation insurance carrier within seven (7) days of knowledge of the occurrence of the injury, as required by SDCL 62-6-2.
4. Give a copy of the form to the injured employee.
5. Keep the copy of the First Report of Injury for at least four (4) years from the date of injury, as required by SDCL 62-6-1.

BODY PART CODES

| | | | | | |
|----|----------------------|----|--|----|----------------------------------|
| 02 | Blindness one eye | 44 | Chest, including ribs sternum, soft ribs | 78 | Ring finger at metacarpal bone |
| 03 | Blindness both eyes | 48 | Internal organs-other than heart, lungs | 79 | Ring finger at proximal joint |
| 04 | Deafness both ears | 49 | Heart | 80 | Ring finger at middle joint |
| 05 | Deafness one ear | 51 | Hip | 81 | Ring finger at distal joint |
| 10 | Multiple head injury | 52 | Upper leg | 82 | Little finger at metacarpal bone |
| 11 | Skull | 53 | Knee | 83 | Little finger at proximal joint |
| 12 | Brain | 54 | Lower leg | 84 | Little finger at middle joint |
| 13 | Ear(s) | 55 | Ankle | 85 | Little finger at distal joint |
| 14 | Eye(s) | 56 | Foot | 86 | Great toe metatarsal bone |
| 17 | Mouth | 57 | Toe (other than greater) | 87 | Great toe at proximal joint |
| 19 | Face (facial bones) | 58 | Toe (greater) | 88 | Great toe at distal joint |
| 20 | Multiple neck injury | 60 | Lungs | 90 | Multiple injury |
| 21 | Vertebrae | 61 | Groin | 92 | Other toe metatarsal bone |
| 22 | Disc | 67 | Thumb metacarpal bone | 93 | Other toe at proximal joint |
| 24 | Other | 68 | Thumb at proximal joint | 94 | Other toe at middle joint |
| 31 | Upper arm | 69 | Thumb at distal joint | 95 | Other toe at distal joint |
| 32 | Elbow | 70 | Index finger at metacarpal bone | 96 | Little toe metatarsal bone |
| 33 | Lower Arm-forearm | 71 | Index finger at proximal joint | 97 | Little toe at distal joint |
| 34 | Wrist | 72 | Index finger at middle joint | | |
| 35 | Hand | 73 | Index finger at distal joint | | |
| 37 | Thumb | 74 | Middle finger at metacarpal bone | | |
| 38 | Shoulder | 75 | Middle finger at proximal joint | | |
| 41 | Upper Back | 76 | Middle finger at middle joint | | |
| 42 | Lower Back | 77 | Middle finger at distal joint | | |

Cause of Injury Codes

| | | | |
|----|--|----|--|
| 01 | Body reaction/over reaction (includes chemicals) | 70 | Striking against or stepping on |
| 03 | Temperature extremes | 78 | Struck or injured by moving parts of machine |
| 13 | Caught in/under/between | 81 | Struck or injured, includes knife or sharp object, kicked, bit, etc. – struck by object, worker, patient, etc. |
| 25 | Fall from elevation | 89 | Hostile attack-person in act of crime |
| 29 | Fall from same level | 90 | Other than physical cause of injury |
| 50 | Motor vehicle | 94 | Repetitive motion – callous, blister, etc. |
| 56 | Bending/Lifting | 97 | Repetitive motion-carpal tunnel syndrome, etc. |
| 65 | Machinery/Equipment | 99 | Other |

Nature of injury codes

| | |
|----|----------------------|
| 00 | Not applicable |
| 01 | Allergy |
| 02 | Disfigurement |
| 71 | Occupational disease |
| 72 | Hearing loss |

South Dakota Employer's First Report of Injury

| | | | | | | |
|--|---|--|--|--|---------------------------------------|---|
| E M P L O Y E E | SSN: | Date of Birth: | Gender: M | F | Dependents: | Education: |
| | Name: (Last) | (First) | (Middle initial) | | Less than High School | |
| I N J U R Y / T R E A T M E N T | Mailing Address: | City: | State: | Zip: | Telephone No.: | GED or High School |
| | Employee signature: (X) _____ | Date _____ | | | | Beyond High School |
| I N J U R Y / T R E A T M E N T | Date of Injury: | Time of Injury: | a.m. | p.m. | Fatality Date (if applicable): | (See Codes on Second Page) |
| | County Where Injury Occurred: | Was Safety Equipment Provided? Yes | | or No | | Body Part Injured |
| I N J U R Y / T R E A T M E N T | Time Work Day Began on Date of Injury: | a.m. | p.m. | Was Safety Equipment Used? Yes | or No | (If code 90, Multiple Injury, please specify body part codes for each body part injured.) |
| | Date Returned to Work (if applicable): | Did Injury Occur on Employer Premises? Yes | | or No | | |
| I N J U R Y / T R E A T M E N T | Address or Location of Injury: | | | | | Nature of Injury |
| | Description of Injury: | | | | | |
| I N J U R Y / T R E A T M E N T | Date Employer Notified of Injury: | | | | | Cause of Injury |
| | Injury Reported to: | | | | | |
| I N J U R Y / T R E A T M E N T | Type of Treatment (please check one) | | If treatment sought, please specify provider of treatment: | | | |
| | <input type="checkbox"/> No Treatment <input type="checkbox"/> On-Site Treatment <input type="checkbox"/> Clinic <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalization | | Medical Practitioner, Clinic or Hospital Name: Mailing Address: City: State Zip Telephone No. : | | | |
| EMPLOYER/EMPLOYMENT INFORMATION: | | | | | | |
| Federal ID No.: | | | # Employees: | | Employment Type: Regular or Temporary | |
| Employer Name (DBA): | | | City: | | Emp. Status: FT PT Seasonal Volunteer | |
| Mailing Address: | | | State: | | Date Employee Hired: | |
| City: | | | Zip: | | Employee's Position: | |
| Telephone No. : | | | County Where Employer Located: | | Employee's Time in Current Position: | |
| Employer signature: _____ | | | Date _____ | | Employee's Hours Per Week: | |
| | | | | | Employee's Current Wage: | |
| | | | | | \$ per | |
| CLAIM OFFICE INFORMATION | | | | Check if Claim Office is same as Insurance Provider | | |
| NAICS for Employer Being Insured (Nature of Business): | | | | If not, you must complete the following | | |
| Carrier Code FEIN (Claim Office) | | | | UNDERLYING INSURANCE PROVIDER INFORMATION | | |
| Claim Office | | | | Carrier Code (If applicable) FEIN (Insurance Provider) | | |
| Claim Office Address | | | | Represented Entity Name | | |
| City State ZipCode | | | | Address | | |
| Telephone | | | | City State Zip Code | | |
| Email Address T | | | | Telephone Number | | |
| Claim Office Claim # | | | | Policy Number | | |
| Date Notified Date to DOL | | | | Effective Dates | | |
| | | | | Adjuster/Contact Person | | |

For information regarding the Workers' Compensation System please visit www.sdjobs.org

Revised 11/2018