

# WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL. ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER				REPORT PURPOSE CODE	
		JURISDICTION		JURISDICTION CLAIM NUMBER			
		INSURED REPORT NUMBER					
		EMPLOYER LOCATION ADDRESS (IF DIFFERENT)				LOCATION #	
SIC CODE	EMPLOYER FEIN						PHONE #
<b>CARRIER/CLAIMS ADMINISTRATOR</b>							
CARRIER (NAME, ADDRESS, & PHONE NO.)			POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO.)		
			TO				
			CHECK IF APPROPRIATE				
			<input type="checkbox"/> SELF INSURANCE				
CARRIER FEIN		POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN	
AGENT NAME & CODE NUMBER							
<b>EMPLOYEE/WAGE</b>							
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH	SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE
ADDRESS (INCL. ZIP)			SEX		MARITAL STATUS		OCCUPATION/JOB TITLE
			<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> UNMARRIED SINGLE/DIVORCE	<input type="checkbox"/> MARRIED
PHONE			# OF DEPENDENTS		<input type="checkbox"/> SEPARATED	<input type="checkbox"/> UNKNOWN	NCCI CLASS CODE
RATE	PER:	DAY	MONTH	AVG WEEKLY WAGES	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	WEEK	WEEK	HOUR			DID SALARY CONTINUE?	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>OCCURRENCE/TREATMENT</b>							
TIME EMPLOYEE BEGAN WORK	AM <input type="checkbox"/> PM <input type="checkbox"/>	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM <input type="checkbox"/> PM <input type="checkbox"/>	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED	
DID INJURY/ILLNESSEXPOSURE OCCUR ON EMPLOYER'S PREMISES?			TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE	
<input type="checkbox"/> YES <input type="checkbox"/> NO							
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 SAFTY EQUIPMENT PROVIDED?			YES <input type="checkbox"/> NO <input type="checkbox"/>	NO <input type="checkbox"/>
			WERE THEY USED?			YES <input type="checkbox"/> NO <input type="checkbox"/>	NO <input type="checkbox"/>
PHYSICIAN/HEALTH CARE PROVIDER(NAME & ADDRESS)			HOSPITAL (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"/> HOSPITALIZED >24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
WITNESS (NAME & PHONE #)							
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE				PHONE NUMBER	