

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCLUDING ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE			
		JURISDICTION		JURISDICTION CLAIM NUMBER					
		INSURED REPORT NUMBER							
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION # (IF AVAILABLE)			
INDUSTRY CODE		EMPLOYER FEIN						PHONE #	
CARRIER/CLAIMS ADMINISTRATOR									
CARRIER (NAME, ADDRESS & PHONE #)			POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)				
			TO						
			CHECK IF APPROPRIATE:						
			SELF-INSURANCE						
CARRIER FEIN			POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN			
AGENT NAME & CODE NUMBER									
EMPLOYEE/WAGE									
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SEC. # (IF THERE IS ONE)		DATE HIRED	STATE OF HIRE	
ADDRESS (INCLUDING ZIP)			SEX M MALE F FEMALE U UNKNOWN		MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN		OCCUPATION/JOB TITLE		
							EMPLOYMENT STATUS		
PHONE #			# OF DEPENDENTS		NCCI CLASS CODE				
RATE PER	DAY WEEK	MONTH OTHER	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES	NO	
					DID SALARY CONTINUE?		YES	NO	
OCCURRENCE/TREATMENT									
TIME EMPLOYEE BEGAN WORK	AM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
	PM			CANNOT BE DETERMINED		PM			
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED			
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?			YES	TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE			
			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 RETURNED TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?			YES	NO	
				WERE THEY USED?			YES	NO	
PHYSICIAN/HEALTH-CARE PROVIDER (NAME & ADDRESS)				HOSPITAL OR OFF-SITE TREATMENT (NAME & ADDRESS)			INITIAL TREATMENT		
							NO MEDICAL TREATMENT		
							MINOR: BY EMPLOYER		
							MINOR: CLINIC/HOSPITAL		
							EMERGENCY CARE		
							HOSPITALIZED > 24 HOURS		
							FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED		
OTHER									
WITNESS(ES) NAME(S) & PHONE #(S)									
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE			PHONE NUMBER		