

# 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 #				
<b>CARRIER/CLAIMS ADMINISTRATOR</b>												
CARRIER (NAME, ADDRESS & PHONE #)			POLICY PERIOD TO			CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)						
			CHECK IF APPROPRIATE: 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 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				
<b>OCCURRENCE/TREATMENT</b>												
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				
<b>OTHER</b>												
WITNESS(ES) NAME(S) & PHONE #(S)												
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER				