

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE					
1. Insured Report Number	2. Filing Office Claim Number		3. OSHA Log Case Number		
EMPLOYER					
4. Employer Business Name			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2		
7. City	8. State	9. Zip	12. City	13. State	14. Zip
15. Federal ID Number		16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE					
18. Insurer Name			21. Filing Office Name		
19. Insurer Federal ID Number			22. Mailing Address 1		
20. Type Insurer Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>			23. Mailing Address 2 or Telephone Number		
			24. City	25. State	26. Zip
			27. Filing Office Federal ID Number		
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male <input type="checkbox"/>		42. Nbr of Dependents
36. City			Female <input type="checkbox"/>		
43. Marital Status Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					44. Date Hired
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$			49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>			50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT					
51. Date of Injury	52. Time of Injury a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		53. Time Employee Began Work a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		54. Date Disability Began
55. Date of Death					
PLACE OF ACCIDENT, INJURY, OR EXPOSURE			61. Injury Occurred on Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>		
56. Site Address			62. Date Employer Notified		
57. City			58. State		59. Zip
60. County					
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)					
PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC)					
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code	
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility	
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		69. Address	
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		70. City	
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		71. State	72. Zip
73. Name of Physician or Other Health Care Professional			74. Has Injured Returned to Work Yes <input type="checkbox"/> No <input type="checkbox"/>		If so, 75. Date 76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
OTHER					
77. Date Prepared	78. Preparer's First Name		79. Last Name		80. Title
					81. Preparer's Telephone Number

STATE OF ALABAMA WORKERS' COMPENSATION INFORMATION



If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE
CARRIER _____

TELEPHONE NUMBER _____

**ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS'
COMPENSATION LAW INCLUDING MEDIATION SERVICE.**

FOR INFORMATION CALL:

1-800-528-5166

**Alabama Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131**

**CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE
POSTED**

IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

FORM WCC#1 10/12