WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Name
Address
City State
Zip
INDUSTRY CODE
EMPLOYER FEIN

CARRIER/ADMINISTRATOR CLAIM | OSHA LOG | REPORT PURPOSE
JURISDICTION | JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #
Address
City State Zip | PHONE #

CARRIER (NAME, ADDRESS, & PHONE #)
Name
Address
City State
Zip Phone
CARRIER FEIN
POLICY/SELF-INSURED NUMBER

POLICY PERIOD
TO
CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Name
Address
City State
Zip Phone
ADMINISTRATOR FEIN

EMPLOYEE Last Name | Middle
First Name
Address
City State
Zip Phone
OF DEPENDENTS

DATE OF BIRTH | SOCIAL SECURITY | DATE HIRED | STATE OF HIRE
SEX
◯ Male
◯ Female
◯ Unknown
MARITAL STATUS
◯ Unmarried Single/Divorced
◯ Married
◯ Separated
◯ Unknown
OCCUPATION/JOB TITLE
EMPLOYMENT STATUS
NCCI CLASS CODE

WAGE RATE | PER: ◯ Day ◯ Week ◯ Month ◯ Other | # DAYS WORKED/WEEK
FULL PAY FOR DAY OF INJURY? ◯ Yes ◯ No
DID SALARY CONTINUE? ◯ Yes ◯ No

TIME EMPLOYEE BEGAN ◯ AM ◯ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ◯ AM ◯ PM ◯ Unknown | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME | CONTACT PHONE | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ◯ Yes ◯ No
TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE
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 SAFETY EQUIPMENT PROVIDED? ◯ Yes ◯ No
WERE THEY USED? ◯ Yes ◯ No

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)
Name
Address
City State

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)
Name
Address
City State

INITIAL TREATMENT
◯ NO MEDICAL TREATMENT
◯ MINOR BY EMPLOYER
◯ MINOR CLINIC/HOSP
◯ EMERGENCY CARE
◯ HOSPITALIZED > 24 HOURS
◯ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESS NAME | PHONE

ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

PREPARER'S EMAIL ID:

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