MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

First Report of Injury

See Instructions on Reverse Side

PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT

Reset

FR01

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. DATE OF CLAIMED INJURY	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. EMPLOYEE Name (last, suffix, first, middle)		8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried
10. Home address		11. Home phone #	12. Date of birth / 13. Date hired
City State Zip Code		14. Occupation	15. Regular department / 16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S)	21. Employment status (check all that apply)
				☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. First date of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI	
	28. Date employer notified of injury	29. Date employer notified of lost time	
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No	32. RTW with restrictions ☐ Yes ☐ No
33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated		
35. Certified Managed Care Organization (if any)			

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
38. **Mailing** address	39. Employer FEIN	40. Unemployment ID #
City State Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet	
City State Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☐ Insurer ☐ TPA		
47. Insured legal name and FEIN	52. CA address		
48. Policy # (including effective dates) or self-insured certificate #	City State Zip Code		
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. CA claim #

55. To be completed by the **CA**:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see www.usa.gov/Business/Business-Gateway.shtml and click on "Get an Employer ID Number".
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR

The following data elements must be completed on this form prior to filing with the Department of Labor and Industry: employee's name and social security number; date of injury; and the names of the employer and insurer. If any of this information is missing, the First Report will be rejected and returned to you (see Minn. Stat. § 176.275). Providing the name of the third party administrator does not meet the statutory requirement to provide the name of the insurer. NOTE: If the claim does not involve lost time beyond the waiting period or potential PPD, the form does **NOT** need to be filed with the Department.

- Item 46: Fill in the name of the insurance company. If the employer is self-insured, indicate the name of the licensed or public self-insured company or group.
- Items 47-48: Fill in the legal name and Federal Employer Identification Number (FEIN) of the employer who purchased the policy from the insurer (named in Item 46) and the policy number. If the employer is licensed to self-insure, fill in the certificate number.
- Item 49: Fill in the insurer's FEIN.
- Item 51: Fill in the name and address of the company administering the claim (either the insurer or third party administrator). Be sure to mark either the "Insurer" or "TPA" box.
- Item 53-54: Fill in the claims administrator's FEIN and claim number.
- Item 55: These items apply only to FROIs electronically submitted by the claim administrator.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Minnesota Workers' Compensation
Employee rights and responsibilities

This notice is required by law to be posted in a conspicuous location wherever the employer is engaged in business.

If you are injured:

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not timely report the injury to your employer. The time limit may be as short as 14 days, although under certain circumstances, it may be longer.
- Provide your employer with as much information as possible about your injury so that a proper injury report can be filed.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you if you are covered by a CMCO.
- Cooperate with all requests for information concerning your workers' compensation claim. Please note: the law provides that the workers' compensation insurer can obtain medical information specific to your work injury without your authorization, provided you are sent written notification of this request at the time the request is made.
- Get written confirmation from your doctor on any authorization to be off work.

What does workers' compensation pay for?

- Medical care for your work injury, as long as it is reasonable and necessary;
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start);
- Compensation for permanent damage to or loss of function of a body part;
- Benefits to your spouse and/or dependents if you die as a result of a work injury;
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury.

What the insurance company must do:

- Investigate your claim promptly;
- Within 14 days of when the claimed injury occurred or when your employer became aware of it, either begin payment of benefits due or file a denial of liability, explaining why benefits are being denied.

Insurer name:	Phone number:

If the insurer *accepts* your claim for wage-loss benefits and you have been disabled for more than three calendar-days:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating your claim is accepted.

- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer *denies* your claim for wage-loss benefits:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.

- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.

- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to discuss your options.

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Any theft of more than $500 is a felony.

Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3.

A suspected fraud can be reported by anyone. If you have reason to suspect someone is committing workers' compensation fraud, call 1-888-FRAUD MN (1-888-372-8366). All suspected violations will be investigated.

If you have questions or need more help, call the Minnesota Department of Labor and Industry:

Workers' Compensation Hotline
1-800-DIAL-DLI
(1-800-342-5354)
8 a.m. to 4:30 p.m.,
Monday-Friday

Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221
Phone: (651) 284-5032
TDD: (651) 297-4198

Department of Labor and Industry
Workers' Compensation Division
525 Lake Ave. S., Suite 330
Duluth, MN 55802-2368
Phone: (218) 733-7810
Toll-free: 1-800-342-5354

Your call will be answered by experienced workers' compensation specialists who will provide **instant, accurate information and assistance.** Additional workers' compensation information is available on the department Web site at *www.dli.mn.gov*.

September 2008

Seguro de compensación a trabajadores por accidentes en el trabajo de Minnesota. Derechos y responsabilidades de los empleados

Minnesota Workers' Compensation Employee's rights and responsibilities (Spanish)

La ley requiere que este aviso se coloque en un lugar visible dondequiera que una empresa lleve a cabo actividades comerciales

Si usted se lesiona:

- Infórmele a su supervisor cualquier lesión que sufra tan pronto como sea posible, independientemente de cuán leve parezca ser. Es posible que pierda su derecho a recibir beneficios del seguro de compensación a trabajadores por accidentes en el trabajo si no le informa oportunamente a su empleador que sufrió una lesión. Es posible que el plazo límite para informar sea sólo 14 días, aunque puede ser más largo bajo ciertas circunstancias.
- Proporciónele a su empleador la mayor cantidad de información que sea posible acerca de su lesión, de manera que pueda hacerse el informe de lesión correspondiente.
- Obtenga cualquier tratamiento médico que sea necesario tan pronto como sea posible. Si no tiene cobertura bajo una organización certificada de atención administrada (certified managed care organization - CMCO), puede acudir a cualquier médico de su elección para recibir el tratamiento. Su empleador debe notificarle si está cubierto bajo una organización CMCO.
- Coopere con todas las solicitudes de información acerca de su reclamación de compensación a trabajadores. Tome nota: la ley estipula que la compañía de seguro de compensación a trabajadores podrá obtener información médica relacionada específicamente con su lesión en el trabajo sin la autorización suya, siempre y cuando le envíe un aviso por escrito de dicha solicitud al momento de hacerla.
- Obtenga confirmación por escrito de su médico de cualquier autorización para ausentarse del trabajo.

¿Qué le paga su seguro de compensación?

- Atención médica por su lesión en el trabajo, siempre y cuando la misma sea razonable y necesaria.
- Beneficios parciales por pérdida de ingresos. (Hay un período de espera de tres días civiles antes de que comiencen estos beneficios.)
- Compensación por daños permanentes o por la pérdida del funcionamiento de una parte del cuerpo.
- Beneficios a su cónyuge y/o sus dependientes si usted fallece como resultado de una lesión en el trabajo.
- Servicios de rehabilitación vocacional si, a causa de una lesión en el trabajo, usted no puede regresar al trabajo que tenía o a la empresa para la que trabajaba antes de sufrir dicha lesión.

Lo que debe hacer la compañía de seguro:

- Investigar su reclamación de manera puntual.
- Comenzar a pagarle los beneficios, o presentar un rechazo de responsabilidad que explique por qué le están negando la solicitud de beneficios, dentro de un plazo de 14 días de usted haber sufrido la lesión por la cual hizo la reclamación o de que su empleador se haya enterado de la misma.

Nombre del asegurador:	Número telefónico:

Si el asegurador *acepta* su reclamación de beneficios por pérdida de ingresos y usted ha estado incapacitado por más de tres días civiles:

- El asegurador le enviará una copia del formulario de *Aviso de Determinación de Responsabilidad Principal del Asegurador* (Notice of Insurer's Primary Liability Determination) indicando que aceptó su reclamación.
- El asegurador deberá comenzar a pagarle los beneficios por pérdida de ingresos dentro de un plazo de 14 días desde que su empleador se haya enterado de su lesión en el trabajo y de su pérdida de ingresos. El asegurador deberá pagar los beneficios de manera puntual. Los beneficios por pérdida de ingresos se pagan a los mismos intervalos de tiempo que sus cheques de nómina.

Si el asegurador *rechaza* su reclamación de beneficios por pérdida de ingresos:

- El asegurador le enviará una copia del formulario de *Aviso de Determinación de Responsabilidad Principal del Asegurador* (Notice of Insurer's Primary Liability Determination) indicando que está rechazando la responsabilidad principal por su reclamación. El formulario debe explicar claramente los hechos y los motivos por los cuales el asegurador cree que su lesión o enfermedad no resultó de su trabajo.
- Si usted no está de acuerdo con el rechazo, debe hablar con el tasador de reclamaciones de seguro que esté encargado de su reclamación. La compañía de seguros de su empleador podrá responder a la mayoría de sus preguntas acerca de su reclamación.
- Si no está satisfecho con la respuesta que reciba del empleador y aún no está de acuerdo con el rechazo, debe comunicarse con el Departamento del Trabajo y la Industria llamando a uno de los números que se indican a continuación para hablar acerca de sus opciones.

Fraude

Cobrar beneficios de compensación a trabajadores por accidentes en el trabajo si usted no tiene derecho a los mismos constituye robo. Cualquier robo de más de $500 constituye un delito grave.

Cualquier persona que, con la intención de defraudar, reciba beneficios de compensación a trabajadores por accidentes en el trabajo a los que la misma no tiene derecho, haciendo declaraciones falsas o inexactas, u ocultado cualquier hecho substancial, es culpable de robo y recibirá una sentencia de conformidad con la sección 609.52, subdivisión 3.

Cualquier persona puede informar una sospecha de fraude. Si usted tiene algún motivo de sospechar que alguien está cometiendo fraude de compensación a trabajadores por accidentes en el trabajo, llame al 1-888-FRAUD MN (1-888-372-8366). Se investigará toda sospecha de infracción.

Si tiene preguntas o necesita más ayuda, llame al Departamento del Trabajo y la Industria de Minnesota:

Línea directa de compensación a trabajadores

1-800-DIAL-DLI
(1-800-342-5354)
de 8 a.m. a 4:30 p.m.,
de lunes a viernes

Departamento del Trabajo y la Industria
División de Compensación a Trabajadores por Accidentes en el Trabajo
P.O. Box 64221
St. Paul, MN 55164-0221
Teléfono: (651) 284-5032
TDD: (651) 297-4198

Departamento del Trabajo y la Industria
División de Compensación a Trabajadores por Accidentes en el Trabajo
525 Lake Ave. S., Suite 330
Duluth, MN 55802-2368
Teléfono: (218) 733-7810
Línea gratuita: 1-800-342-5354

Especialistas en compensación a trabajadores con experiencia responderán a su reclamación y le proveerán **información y asistencia instantáneas y precisas.** Hay información adicional acerca de la compensación a trabajadores por accidentes en el trabajo disponible en el sitio de Internet del departamento en *www.dli.mn.gov.*

September 2008

Este documento está disponible en formatos alternativos como Braille o audiocinta llamando al (651) 284-5042 o al (651) 297-4198/TDD.