

## WORKERS' COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL 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 #
INDUSTRY CODE	EMPLOYER FEIN	PHONE #			
<b>CARRIER/CLAIMS ADMINISTRATOR</b>					
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)		
		CHECK IF APPROPRIATE <input type="checkbox"/> 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 SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	MARITAL STATUS <input type="checkbox"/> Unmarried/Single/Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	OCCUPATION/JOB TITLE	
				EMPLOYMENT STATUS	
PHONE		# OF DEPENDENTS	NCCI CLASS CODE		
RATE PER:	<input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
			DID SALARY CONTINUE?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>OCCURRENCE/TREATMENT</b>					
TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( <input type="checkbox"/> ) CANNOT BE DETERMINED <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN	
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED	
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE	
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 RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
		WERE THEY USED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT	
				0 <input type="checkbox"/> NO MEDICAL TREATMENT	
				1 <input type="checkbox"/> MINOR: BY EMPLOYER	
				2 <input type="checkbox"/> MINOR CLINIC/HOSP	
				3 <input type="checkbox"/> EMERGENCY CARE	
				4 <input type="checkbox"/> HOSPITALIZED > 24 HOURS	
				5 <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
<b>OTHER</b>					
WITNESSES (NAME & PHONE #)					
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE		PHONE NUMBER	