State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)*	Phone # 732-987-3817
Tender Touch Rehab CT 685 River Ave Lakewood NJ 08701	
SIC Code	FEIN 38-4006375
Carrier / Administrator Claim #	OSHA Log Case # / Report Purpose Code
Jurisdiction	Jurisdiction Claim #
Employer's Location Address *(if different)*	Phone #
Carrier *(Name, Address & Zip)*	Phone #
Claims Administrator *(Name, Address & Zip)*	Phone #
Policy / Self-Insured #	☐ Check, if Self-Insured
Policy Period *(MM/DD/YY)* FROM:	TO:

Employee: Last Name	First Name	Middle Name	Gender
makwana	megha	gg	☐ Male ■ Female
D.O.B. *(required)* 04/30/2021	Phone #		
Address *(incl. Zip)* 52525			

Date Hired *(MM/DD/YY)* 04/30/2021	State of Hire AR
Occupation / Job Title SLP	
Rate of Pay $_____ . _____ per ☐ Hour ☐ Day ■ Week ☐ Bi-Weekly ☐ Other	NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)* 04/30/2021	Town of Injury / Illness kmnk
Time Employee Began Work 04/30/2021 05:11 ☐ a.m. ■ p.m.	Did Injury / Illness occur on Employer's Premises? ☐ Yes ■ No
Time of Occurrence ☐ cannot be determined 04/30/2021 - 05:11 ☐ a.m. ■ p.m.	Type of Injury / Illness Dislocation
Date Employer Notified *(MM/DD/YY)* 04/30/2021	Part of Body Affected Part of Body Affected Part of Body
Date Disability Began *(MM/DD/YY)* 04/30/2021	Type of Injury / Illness Code
Date Last Worked *(MM/DD/YY)* 04/30/2021	Part of Body Affected Code
Date Return(ed) to Work *(MM/DD/YY)*	Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No If provided, were they used? ☐ Yes ☐ No
If Fatal, Date of Death *(MM/DD/YY)*	How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill: How injury / illness occurred – describe the sequences of events, including any object or substances that directly injured the employee or made the employee il
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:	
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred: SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	
Contact Name megha makwana	
Phone #	Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*
Physician / Health care provider (name address & ZIP)Physician / Health care provider (name address & ZIP)

Hospital *(Name, Address & Zip)*
Physician / Health care provider (name address & ZIP)Physician / Health care provider (name address & ZIP)

Initial Treatment

- ■ No Medical Treatment
- ■ Emergency Care
- ■ Minor — by Employer
- ■ Hospitalized More Than 24 Hours
- ■ Minor — by Clinic / Hospital
- ■ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* 04/30/2021	Date Prepared *(MM/DD/YY)* 04/30/2021
Preparer's Name & Title Joyce Ginsberg, HR Benefits Manager	Phone # 214-523-2222