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

Date filed in Chairman's Office

(for WCC use only)

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.

Employer *(Name, Address & Zip)*

Tender Touch Rehab
685 River Ave
Lakewood, NJ 08701

Phone # **732 987 3817**

SIC Code

FEIN **38 400 6375**

Carrier / Administrator Claim #

OSHA Log Case #

Report Purpose Code

Jurisdiction

Jurisdiction Claim #

Employer's Location Address *(if different)*

Villa At Stamford
88 Rock Rimmon Road
Stamford, CT 06903

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

D.O.B. *(required)*

Phone #

Address *(incl. Zip)*

Gender

☐ Male

☒ Female

Date Hired *(MM/DD/YY)*

State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per

☒ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☒ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☒ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

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:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☒ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(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)*

Date Prepared *(MM/DD/YY)*

Preparer's Name & Title

Phone # **732-987-3899**