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)*	Phone #	Carrier / Administrator Claim #	OSHA Log Case #	Report Purpose Code
Tender Touch Rehab CT 685 River Ave Lakewood NJ 08701	732-987-3817			
		Jurisdiction	Jurisdiction Claim #	
		Employer's Location Address *(if different)*	Phone #	
SIC Code	FEIN 38-4006375			

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	megha1815	mehul	☐ Male ■ Female
D.O.B. *(required)* 04/27/2021	Phone # 454-555-5555		
Address *(incl. Zip)* 23/2 shivam flats bapunagar ahmedabad 380024			

Date Hired *(MM/DD/YY)*	State of Hire
04/27/2021	AR
Occupation / Job Title: COTA	
Rate of Pay $_____ . _____ per ☐ Hour ☐ Day ■ Week ☐ Bi-Weekly ☐ Other	NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*	Town of Injury / Illness	Physician / Health Care Provider *(Name, Address & Zip)*
04/27/2021	AHMEDABAD	23/2 shivam flarts near anand flats police choki 380024 23/2 shivam flarts near anand flats police choki 380024
Time Employee Began Work ☐ a.m. ■ p.m.: 04/27/2021 06:17	Did Injury / Illness occur on Employer's Premises? ■ Yes ☐ No	
Time of Occurrence ☐ cannot be determined: 04/27/2021 - 06:17 ☐ a.m. ■ p.m.	Type of Injury / Illness: Concussion	
Date Employer Notified *(MM/DD/YY)*: 04/27/2021	Part of Body Affected: Part of Part of Body Affected Body	Hospital *(Name, Address & Zip)*: .Hospital (Name, address & zip).Hospital (Name, address & zip)
Date Disability Began *(MM/DD/YY)*: 04/27/2021	Type of Injury / Illness Code	
Date Last Worked *(MM/DD/YY)*: 04/27/2021	Part of Body Affected Code	
Date Return(ed) to Work *(MM/DD/YY)*: 04/30/2021	Were Safeguards or Safety Equipment provided? ■ Yes ☐ No If provided, were they used? ■ Yes ☐ No	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
If Fatal, Date of Death *(MM/DD/YY)*: 04/27/2021	How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill: dd	
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred: ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING		
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred: PECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE		
Contact Name: Joyce Ginsberg Phone #	Cause of Injury Code	

Date Administrator Notified *(MM/DD/YY)*	Date Prepared *(MM/DD/YY)*
04/27/2021	04/27/2021
Preparer's Name & Title: Joyce Ginsberg, HR Benefits Manager	Phone # 732-987-3817