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
CT 685 River Ave
Lakewood NJ 08701

Phone # 732-987-3817

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: TEST
First Name: TODAY
Middle Name: ABC

D.O.B. *(required)* 10/22/2021

Phone #

Address *(incl. Zip)*
sf

Gender
■ Male
☐ Female

Date Hired *(MM/DD/YY)* 10/28/2021

State of Hire: TODAY

Occupation / Job Title: Rehab Aide

Rate of Pay $_____ . _____ per

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

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)* 05/13/2021

Time Employee Began Work: 05/10/2021 10:05 ■ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined: 05/10/2021 - 12:00 ■ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)* 10/22/2021

Date Disability Began *(MM/DD/YY)* 05/20/2021

Date Last Worked *(MM/DD/YY)* 06/13/2021

Date Return(ed) to Work *(MM/DD/YY)* 06/16/2021

If Fatal, Date of Death *(MM/DD/YY)* 05/19/2021

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:
dsf

Contact Name: Joyce Ginsberg

Phone #

Town of Injury / Illness: fdsf

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

Type of Injury / Illness: Sprain/Strain

Part of Body Affected: sdf

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:
ds

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)* 10/22/2021

Date Prepared *(MM/DD/YY)* 10/22/2021

Preparer's Name & Title: Joyce Ginsberg, HR Benefits Manager

Phone # 732-987-3817