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	Date Hired *(MM/DD/YY)*	State of Hire
sad	sadsd	sdsa		05/26/2021	AZ
D.O.B. *(required)* 05/26/2021	Phone #		■ Male	Occupation / Job Title SLP	
Address *(incl. Zip)* w			☐ Female	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)*
05/27/2021	dsd	
Time Employee Began Work 05/03/2021 11:01 ■ a.m. ☐ p.m.	Did Injury / Illness occur on Employer's Premises? ☐ Yes ■ No	
Time of Occurrence ☐ cannot be determined 05/03/2021 - 11:01 ■ a.m. ☐ p.m.	Type of Injury / Illness: Dislocation	
Date Employer Notified *(MM/DD/YY)* 05/03/2021	Part of Body Affected: dsdds	Hospital *(Name, Address & Zip)*
Date Disability Began *(MM/DD/YY)* 05/19/2021	Type of Injury / Illness Code	
Date Last Worked *(MM/DD/YY)* 05/20/2021	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	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)*	How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill: dsdsddddddd	
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: dsd		
Contact Name Joyce Ginsberg Phone #	Cause of Injury Code	

Date Administrator Notified *(MM/DD/YY)*	Date Prepared *(MM/DD/YY)*
05/03/2021	05/03/2021
Preparer's Name & Title: Joyce Ginsberg, HR Benefits Manager	Phone # 732-987-3817