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)* Tender Touch Rehab CT 685 River Ave Lakewood NJ 08701	Phone # 732-987-3817	Carrier / Administrator Claim #	OSHA Log Case # / Report Purpose Code
		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: makwana	First Name: mega1641	Middle Name: mehul	Gender: ☐ Male ☒ Female
D.O.B. *(required)* 4/23/21	Phone #		
Address *(incl. Zip)* 44			
Date Hired *(MM/DD/YY)*	State of Hire: AZ		
Occupation / Job Title: PTA			
Rate of Pay $____ . ____ per ☐ Hour ☒ Day ☐ Week ☐ Bi-Weekly ☐ Other	NCCI Class Code		

Date of Injury / Illness *(MM/DD/YY)*: 4/23/21	Town of Injury / Illness	Physician / Health Care Provider *(Name, Address & Zip)*
Time Employee Began Work: 2021-04-23 ☐ a.m. ☐ p.m.	Did Injury / Illness occur on Employer's Premises? ☐ Yes ☒ No	
Time of Occurrence ☐ cannot be determined: 4/23/21 - 0 ☐ a.m. ☒ p.m.	Type of Injury / Illness: Sprain/Strain	
Date Employer Notified *(MM/DD/YY)*: 4/23/21	Part of Body Affected: hh	Hospital *(Name, Address & Zip)*
Date Disability Began *(MM/DD/YY)*: 4/23/21	Type of Injury / Illness Code	
Date Last Worked *(MM/DD/YY)*: 4/23/21	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: hh	
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: hh		Date Administrator Notified *(MM/DD/YY)*: 4/23/21 Date Prepared *(MM/DD/YY)*: 4/23/21
Contact Name: Jovce Ginsberg		Preparer's Name & Title Phone # Joyce Ginsberg, HR Be
Phone #	Cause of Injury Code	