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

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: makwana | First Name: megha AB | Middle Name: mehul

D.O.B. *(required)* 05/03/2021

Phone # 454-545-4555

Address *(incl. Zip)*
ddf

Gender
☐ Male
■ Female

Date Hired *(MM/DD/YY)* 05/03/2021

State of Hire AZ

Occupation / Job Title
COTA

Rate of Pay $_____ . _____ per

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

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)* 05/03/2021

Time Employee Began Work 05/03/2021 04:51 ☐ a.m. ■ p.m.

Time of Occurrence ☐ cannot be determined
05/03/2021 - 04:51 ☐ a.m. ■ p.m.

Date Employer Notified *(MM/DD/YY)* 05/03/2021

Date Disability Began *(MM/DD/YY)* 05/03/2021

Date Last Worked *(MM/DD/YY)* 05/03/2021

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:
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

Contact Name megha makwana

Phone #

Town of Injury / Illness: ahmedabd

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

Type of Injury / Illness: Concussion

Part of Body Affected: hh

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:
How injury / illness occurred – describe the sequences of events, including any object or substances that directly injured the employee or made the employee il

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*
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)* 05/03/2021

Date Prepared *(MM/DD/YY)* 05/03/2021

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

Phone # 214-523-2222