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: Patel	First Name: Harshil	Middle Name: Balvantbha	Gender: ☒ Male ☐ Female
D.O.B. *(required)* 12/12/2020	Phone # 48465546		
Address *(incl. Zip)* Rate of Pay			
Date Hired *(MM/DD/YY)*	State of Hire: IA		
Occupation / Job Title: 10. Occupation / Job Title *			
Rate of Pay $_____ . _____ per ☐ Hour ☒ Day ☐ Week ☐ Bi-Weekly ☐ Other	NCCI Class Code		

Date of Injury / Illness *(MM/DD/YY)*: 12/15/2020	Town of Injury / Illness: Town of Injury / Illness	Physician / Health Care Provider *(Name, Address & Zip)*
Time Employee Began Work ☐ a.m. ☐ p.m.	Did Injury / Illness occur on Employer's Premises? ☐ Yes ☒ No	
Time of Occurrence ☐ cannot be determined 01/19/2021 ☒ a.m. ☐ p.m.	Type of Injury / Illness	
Date Employer Notified *(MM/DD/YY)*: 12/12/2020	Part of Body Affected: Part of Body Affected	Hospital *(Name, Address & Zip)*
Date Disability Began *(MM/DD/YY)*: 12/12/2020	Type of Injury / Illness Code	
Date Last Worked *(MM/DD/YY)*: 12/12/2020	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	
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: 26. How injury / illness occurred – describe the sequences of events, including any object or substances that directly injured the employee or made the employee il *	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
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: social_security_num		Date Administrator Notified *(MM/DD/YY)*: 03/25/2021 Date Prepared *(MM/DD/YY)*: 03/25/2021
Contact Name: Jovce Ginsberg Phone #	Cause of Injury Code	Preparer's Name & Title Phone # Joyce Ginsberg