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	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: megha1829	Middle Name: mehul	Gender: ☐ Male ■ Female
D.O.B. *(required)*	Phone #		
Address *(incl. Zip)*: 23/2 shivam bapunagar ahmedabad			
Date Hired *(MM/DD/YY)*	State of Hire: AK		
Occupation / Job Title: OT			
Rate of Pay $____ . ____ per ☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other	NCCI Class Code		

Date of Injury / Illness *(MM/DD/YY)*: 04/27/2021	Town of Injury / Illness: Ahmedabad	Physician / Health Care Provider *(Name, Address & Zip)*: Nikol 333
Time Employee Began Work: 2021-04-27 18:29:00 ☐ a.m. ☐ p.m.	Did Injury / Illness occur on Employer's Premises? ☐ Yes ■ No	
Time of Occurrence: 04/27/2021 - 06:32 ☐ cannot be determined ☐ a.m. ■ p.m.	Type of Injury / Illness: Dislocation	
Date Employer Notified *(MM/DD/YY)*: 04/27/2021	Part of Body Affected: dd	Hospital *(Name, Address & Zip)*: Hospital (Name, address & zip)
Date Disability Began *(MM/DD/YY)*: 04/27/2021	Type of Injury / Illness Code	
Date Last Worked *(MM/DD/YY)*: 04/27/2021	Part of Body Affected Code	
Date Return(ed) to Work *(MM/DD/YY)*: 04/30/2021	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)*: 04/27/2021	How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill: dd	
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: dd		
Contact Name: megha makwana Phone #	Cause of Injury Code	Date Administrator Notified *(MM/DD/YY)*: 04/27/2021 Date Prepared *(MM/DD/YY)*: 04/27/2021 Preparer's Name & Title: Joyce Ginsberg, HR Benefits Manager Phone #: 214-523-2222