North Dakota
Workforce Safety
& Insurance
Putting Safety to Work

WSI

FIRST REPORT OF INJURY

SFN 2828 (08/2012)

1600 EAST CENTURY AVENUE, SUITE 1
PO BOX 5585
BISMARCK ND 58506-5585
Telephone 1-800-777-5033
Toll Free Fax 1-888-786-8695
TTY (hearing impaired) 1-800-366-6888
Fraud and Safety Hotline 1-800-243-3331
www.WorkforceSafety.com

PLEASE PRINT OR TYPE USING BLACK OR BLUE INK AND RETURN TO WSI. Please see reverse side for Fraud Warning and other information.

SECTION 1
Completion of this section is required

Claim Number	Worker's Name	Social Security Number	Injury Date	Time of Injury ☐ AM ☐ PM	Birth Date

Worker's Mailing Address (Street Address, PO Box Number)	Sex ☐ F ☐ M	Marital Status ☐ Single ☐ Married

City	State	Zip	Worker's Home/Cell Phone Number

Body Part Injured (*Example: Left 2nd/middle finger, right shoulder, left ankle.*)	What was the nature of the injury or illness? (*Example: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*)

Tell us how the injury occurred and what the worker was doing before the incident (give details). *(Example: "Worker was driving lift truck with pallet of boxes when the truck tipped, pinning driver's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry.")*

Name of Treating Doctor(s)	Clinic/Hospital	E. R. Visit ☐ Yes ☐ No	Overnight Stay ☐ Yes ☐ No	Date of First Treatment ☐ N/A

Address	City	State	Zip	Doctor's Phone Number

Employer's Name	What is the worker's occupation? (job title or duties)

Employer's Address	City	State	Zip	Employer's Phone Number

If job site, list location - (city, county, state, and zip)	Employer's Premises ☐ Job Site ☐	Time Worker Began Shift ☐ AM ☐ PM	When did worker last work in ND?	Date Hired

SECTION 2
Worker Completion

Date employer notified and person you notified:	Have you had prior problems or injuries to that part of the body? ☐ Yes ☐ No

Witness(es) to the Injury	Address of Witness(es)	Has or will the incident cause you to miss five or more days of work? ☐ Yes ☐ No

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including records pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS related illness. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

Worker's Signature Date Signed	In addition to myself, I authorize WSI to release information on my claim to: (please print) First Name Last Name Relationship

SECTION 3
Medical Provider Completion

Type of Injury (fracture, bruise, cut, etc.)	Date of First Treatment

Has the incident caused the worker to miss five or more days of work? ☐ Yes ☐ No	Diagnosis condition based upon objective medical findings: **Diagnosis code**:

Has the worker had any prior problems or injuries to that part of the body? ☐ Yes ☐ No If yes, please provide details.

Date worker may return to work: ☐ Without work restrictions ☐ With the following restrictions (list)

Please complete the Physical Lifting Demand Level below – see guide on reverse side.

☐ Sedentary 10 lbs	☐ Light 20 lbs	☐ Medium 50 lbs	☐ Heavy 70 lbs

Other instructions and/or limitations including prescribed medications or PT order:	Prognosis and anticipated length of medical treatment:

The above restrictions are in effect until:	Re-evaluation date:	Time:

Physician's Signature	Date Signed	Physician's Federal Tax ID No.

SECTION 4
Employer Completion

Employer Account Number	Worker's Rate Class	Causation Code **(See reverse)**	OSHA Log Number (See reverse)	Has the incident caused the worker to miss five or more days of work? ☐ Yes ☐ No

Is worker a corp. officer, owner, partner, spouse or child under age 22? ☐ Yes ☐ No	Worker Status: ☐ Full Time; ☐ Part Time; ☐ Seasonal; ☐ Temporary	First day worker lost wages due to work injury: ☐ N/A

Hourly Rate $	Hours Worked Per Week	Gross Earnings YTD $ **From to**	Job description submitted or attached? ☐ Yes ☐ No

Has the worker had any prior problems or injuries to that part of the body ☐ Yes ☐ No	Date employer notified and person notified

Do you have a Designated Medical Provider (DMP)? ☐ Yes ☐ No	If yes, did the worker opt out? ☐ Yes ☐ No	Date of Death (If applicable)

If you question this claim, state reason (continue on back) or attach additional information.

Employer's Signature	Title	Date Signed

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with the Fund, including injured workers, employers, medical providers, and attorneys.

To report an instance of fraud, contact the ND Fraud and Safety Hotline at 1-800-777-5033.Additional information:

For medical provider use:

Physical Demand Level	Occasional (0-3 Hours)	Frequent (3-6 Hours)	Constant (6-8 Hours)
Sedentary	10 lbs.	Negligible	Negligible
Light	20 lbs.	10 lbs. and/or Walk/Stand/Push/Pull of Arm/Leg controls	Negligible and/or Push/Pull of Arm/Leg controls while seated.
Medium	50 lbs.	20 lbs.	10 lbs.
Heavy	70 lbs.	50 lbs.	20 lbs.

For employer use:

Causation Codes:

1. Contact with object and/or equipment
2. Fall to lower level
3. Fall on same level
4. Slip, trip, or loss of balance without fall
5. Overexertion
6. Overexertion lifting
7. Repetitive motion
8. Exposure to harmful substances
9. Transportation accident
10. Fire and/or explosion
11. Assault and/or violent act

For more information regarding the OSHA Log number (OSHA 300 Reference Number), visit http://www.osha.gov/recordkeeping/index.html

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& Insurance
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FIRST REPORT OF INJURY INSTRUCTIONS

SFN 13659 (05/2008)

1600 EAST CENTURY AVENUE, SUITE 1
PO BOX 5585
BISMARCK ND 58506-5585
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Toll Free Fax 1-888-786-8695
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REPORTING TIMEFRAMES

WSI encourages workers and employers to immediately file a claim with WSI (within 24 hours of injury occurrence) as that allows for more effective management of the claim.

WORKER: Under North Dakota law, you must notify your employer of your injury within 7 days after an accident or when the general nature of the injury became apparent.

EMPLOYER: Under North Dakota law, an employer is required to file a First Report of Injury form with Workforce Safety & Insurance (WSI) within 7 days of receiving notice of an injury from a worker.

WAYS TO FILE A CLAIM AND HOW TO SUBMIT YOUR FIRST REPORT OF INJURY

- **Online** at *www.WorkforceSafety.com* (Online Services section)
- **Telephonically** by calling 1-800-777-5033 or (701) 328-3800
- **Fax this completed form** to 1-888-786-8695 or (701) 328-3820
- **Mail this completed form** to WSI, PO Box 5585, Bismarck ND 58506-5585

COMPLETION INSTRUCTIONS *(for assistance, call 1-800-777-5033) or (701) 328-3800*

- **Once WSI receives this form with the appropriate section completed by the worker, medical provider, or employer, a claim will be filed and a claim number assigned.**
- **All parties (meaning the worker, medical provider, and employer) may complete and sign one form or each party may complete an individual form and mail or fax it to WSI or complete a form online.**
- **No decision can be made on this claim until all required information is received.**
- **Be sure to sign and date the appropriate sections.**

SECTION 1
Completion of this section is required

PLEASE PRINT OR TYPE USING BLACK OR BLUE INK AND RETURN TO WSI. Please see reverse side for Fraud Warning and other information.

SECTION 1
Completion of this section is required

Claim Number	Worker's Name	Social Security Number	Injury Date ❶	Time of Injury ☐ AM ☐ PM	Birth Date
Worker's Mailing Address				Sex ☐ F ☐ M	Marital Status ☐ Single ☐ Married
City		State	Zip	Worker's Home/Cell Phone Number	
Body Part Injured (*Example: Left 2nd/middle finger, right shoulder, left ankle.*) ❷		What was the nature of the injury or illness? (*Example: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*) ❸			
Tell us how the injury occurred and what the worker was doing before the incident. Provide details. (*Example: "Worker was driving lift truck with pallet of boxes when the truck tipped, pinning driver's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*) ❹					
Name of Treating Doctor(s)	Clinic/Hospital	E. R. Visit ☐ Yes ☐ No	Overnight Stay ☐ Yes ☐ No	Date of First Treatment ☐ N/A	
Address	City	State	Zip	Doctor's Phone Number	
Employer's Name	What is the worker's occupation? (job title or duties)				
Employer's Address	City	State	Zip	Employer's Phone Number	
If job site, list location - (city, county, state, and zip) ❺	Employer's Premises ☐ Job Site ☐	Time Worker Began Shift ☐ AM ☐ PM	When did worker last work in ND?	Date Hired	

SAMPLE

This section must be completed each time a First Report of Injury is submitted to WSI. **This section may be completed by the worker, medical provider, or employer.**

❶ Please indicate the date the worker was injured or contracted an occupational disease.

❷ Please indicate the body part injured, be specific, Example: *Left 2nd/middle finger, right shoulder, left ankle.*

❸ What the nature of the injury or illness is. Example: *Chemical burn of left hand, broken left leg, carpal tunnel syndrome.*

❹ Please explain how the injury occurred and what the worker was doing before the incident. Provide details. Example: "*Worker was driving lift truck with pallet of boxes when the truck tipped, pinning driver's left leg under drive shaft.*" "*Worker developed soreness in left wrist over time from daily computer key entry.*"

❺ Please give the exact address or location of injury – (city, county, state, and zip).

SECTION 2 Worker Completion

SECTION 2 Worker Completion

Date employer notified and person you notified:		Have you had prior problems or injuries to that part of the body? ❶ ☐ Yes ☐ No
Witness(es) to the Injury	Address of Witness(es)	Have you missed five or more days from work or are currently off work greater than five days? ❷ ☐ Yes ☐ No
I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information, records, and reports pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS related illness. I authorize WSI to release any information or records about my claim to third parties for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.		
Worker's Signature	Date Signed	In addition to myself, I authorize WSI to release information on my claim to: (please print) First Name Last Name Relationship

SAMPLE

The **WORKER** is required to complete, sign, and date this section and submit this form to WSI.

❶ Please indicate if, before this injury, you ever had any injuries or health problems, work related or not, to the area of your body listed in Section 1.

❷ Please indicate if you will miss five or more days of work.

SECTION 3 Medical Provider Completion

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Type of Injury (fracture, bruise, cut, etc.)			Date of First Treatment
Has the incident caused the worker to miss five or more days work or is currently off work greater than five days? ❶ ☐ Yes ☐ No	Diagnosis condition based upon objective medical findings ❷ **Diagnosis code:**		
Has the worker had any prior problems or injuries to that part of the body? ☐ Yes ☐ No If yes, please provide details.			
Date worker may return to work: ☐ Without work restrictions ☐ With the following restrictions (list)			
❸ **Please complete the Physical Lifting Demand Level below – see guide on reverse side.**			
☐ Sedentary 10 lbs	☐ Light 20 lbs	☐ Medium 50 lbs	☐ Heavy 70 lbs
Other instructions and/or limitations including prescribed medications or PT order: ❹		Prognosis and anticipated length of medical treatment: ❺	
The above restrictions are in effect until:		Re-evaluation date:	Time:
Physician's Signature		Date Signed	Physician's Federal Tax ID No.

SAMPLE

The **MEDICAL PROVIDER** is required to complete, sign, and date this section and submit this form to WSI.

❶ Please indicate if the incident will cause the worker to miss five or more days of work.

❷ Please indicate the diagnosis condition based upon objective medical findings and the diagnosis code.

❸ Please complete the Physical Lifting Demand Level – see reverse side of First Report of Injury form for guide.

❹ Please list other instructions and/or limitations including prescribed medications or physical therapy.

❺ Please indicate the prognosis and anticipated length of medical treatment.

SECTION 4 Employer Completion

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Employer Account Number	Worker's Rate Class	Causation Code **(See reverse)**	OSHA Log Number (See reverse)	Has the incident caused worker to miss five or more days from work or is currently off work greater than five days? ☐ Yes ☐ No
Is worker a corp. officer, owner, partner, spouse or child under age 22? ☐ Yes ☐ No		Worker Status: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Temporary		First day worker lost wages due to work injury: ☐ N/A
Hourly Rate $	Hours Worked Per Week	Gross Earnings (YTD) From To		Job description submitted or attached? ☐ Yes ☐ No
Has the worker had any prior problems or injuries to that part of the body ☐ Yes ☐ No				Date employer notified and person notified
Do you have a Designated Medical Provider (DMP)? ☐ Yes ☐ No	If yes, did the worker opt out? ☐ Yes ☐ No			Date of Death (If applicable)
If you question this claim, state reason (continue on back) or attach additional information.				
Employer's Signature	Title			Date Signed

SAMPLE

The **EMPLOYER** is required to complete, sign, and date this section and submit this form to WSI.