North Dakota Workforce Safety & Insurance WSI Putting Safety to Work

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 Fres Fax 1-888-786-8695
TTY (hearing impaired) 1-800-386-6588
Fraud and Safety Hotline 1-800-243-3331
www.WorkforcaSafety.com

& Insurance

PLI	EASE PRINT OR TYPE U		INK AND RI									
	Claim Number	Worker's Name		Social Ser	curity N	umber	Inju	ry Date	Time o	finjury		Birth Date
2					WILL SHIP		□ PI					
adnire	Worker's Mailing Address (Street Address, PO Box Number)								Sex □ F			
S	City	City						Zip		Worker's Home/Cell Phone Number		
SECTION 1 f this section is required	Body Part Injured (Example ankle.)		vas the nature of the injury or illnes tunnel syndrome in left wrist.)			ess? (Example: chemical burn left hand, broken left leg,						
SEC Completion of this	Tell us how the injury occu tipped, pinning driver's left	the incident (soreness in le	(give de left wrist	tails). (Examp over time from	le: "Worl daily co	ker was drivir omputer key e	og lift truck w entry.")	ith palle	et of bo	ixes when the truck		
Comple	Name of Treating Doctor(s		Clinic/Hosp	pital	A ^{MY} /	5 9	E.R.	Visit s □ No	Overnight S	No	Date o	First Treatment
	Address	TORIGHT LINES				City		04.6	State Zip			r's Phone Number
	Employer's Name		What is the wo	cupation? (jo	b title or dut	itle or duties)						
	Employer's Address		City			State Z		Emp	Employer's Phone Number			
	If job site, list location - (city and zip)	y, county, state, Employer Job Site	's Premises	8	Time	Worker Begar [[Shift AM PM	When d	n did worker last worl		in	Date Hired
	Date employer notified and	person you notified:			4,		had prior	problems or i	njuries to tha	t part of	the boo	ly?
2 letion	Witness(es) to the Injury	Addre	ess of Witness	s(es)		1 🗀 103	LJ 140	Has or w	s or will the incident cause you to miss five or sof work?			
SECTION 2	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 employer.											
S Work	Worker's Signature	11	Date S	igned				I authorize WS	to release in	formation	n on my	claim to: (please print)
	Two of labor diseases have				_	First Name		Last Nan	ne			Relationship
	Type of Injury (fracture, bru	ise, cut, etc.)) LE	医皮丸	-	4	1 4	No.		Date	at First	t Treatment
io i	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:										- F. F.	
CTION 3 vider Completion	Has the worker had any prior problems or injuries to that part of the body? Yes No If yes, please provide details.											
ON 3	Date worker may return to work: Without work restrictions							restrictions (NEW COLUMN
		Please complete		Lifting Den	nand Le	evel below - s	CONTRACT.	e on reverse	m marketing			
SE Medical Pro	☐ Sedentary 10 lbs ☐ Light 20 lbs Other instructions and/or limitations including prescribed medications or PT order:					☐ Medium 50 lbs Prognosis and anticipated length of medic				Heavy 70 lbs		
Medic	The above restrictions are in effect until:				Re-evaluation date:				Time:	Time:		
	Physician's Signature	-			Date S	igned			Physicia	n's Fed	leral Ta	x ID No.
	Employer Account Number	Worker's Rate Class	Causation (OSHA (See re	Log Number everse)	Has th		used the wo	rker to n	miss fiv	e or more days of
tion	Is worker a corp. officer, owner, partner, spouse or child Worker Status:					Time; Seasonal; Temporary			First day worker lost wages due to work injury:			
SECTION 4 loyer Completion	Hourly Rate \$	Hours Worked Per Week	Gross Earni From	ings YTD \$			***************************************	Job description submitted or attached? Yes No			?	
SECTION oyer Com	Has the worker had any price	or problems or injuries to that	part of the bod	ly 🗆 🗆	Yes	□No		Date emplo	yer notified	and per	rson no	rtified
SE	Do you have a Designated I ☐ Yes ☐ No		ALL STATES OF THE STATES OF TH	he worker op			□No	Date of Dea	ath (If applic	able)		
2	If you question this claim,	state reason (continue on i	oack) or attac	h additional	inform	ation.						
1-3 6	Employer's Signature	Title					Date Signe	d				

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



FIRST REPORT OF INJURY INSTRUCTIONS

SFN 13659 (05/2008)

1600 EAST CENTURY AVENUE, SUITE 1 PO BOX 5585 BISMARCK ND 58505-5685 Telephone 1-800-777-5033 Toll Free Fax 1-888-786-8695 TTY (hearing impaired) 1-800-66-888 Fraud and Safety Hotline 1-800-243-3331 www.WorkforceSafety.com

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.

Claim Number	Worker's N	lame	Social Securi	ly Number	Injury	Date 0	-37	ne of i	njury	Birth Date
Worker's Mailing	Worker's Mailing Address				-	ri .	1 3	ex] F	Morito:	Status de Married
City	City					Zip		Worker's Hame/Cell Phone Number		
ankle.)	d (Example: Leit 2 st imiddi	carpal tunna	se nature of the injury or diness? (Example: chemical burn left had a yndrone in left wrist.) detail detail					and, broken felt leg		
Tell us how the i tipped, pinning d		staft." Steer Adopt believ to		detail 1 decam	m daily oon	iputer Ney	entry: 7			
Tell us how the introped, planing of Name of Treating		e worker was doing belief to shaft. "Seer Property Clinic/Hosp		detal 1 H-am nat over lime tro	ple: Worke m daily con	uit	Overnic	ght Sta	y Date	of First Treatment
Tell us how the interpret of the period of the period of the state of		<u> </u>		detail	m daily con	uit	Overnic	ght Sta	y Date	of First Treatment
Name of Treation	g Doctor(s)	<u> </u>		mat över lime tro	E.R.V	uit No	Overnic Ves	ght Sta	y Dah	e of First Treatment
Name of Treation	g Doctor(n)	<u> </u>		City	E.R. V	uit No	Overnic Ves	ght Sta	Do	of First Treatment

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.

- Please indicate the date the worker was injured or contracted an occupational disease.
- Please indicate the body part injured, be specific, Example: Left 2nd/middle finger, right shoulder, left ankle.
- What the nature of the injury or illness is. Example: Chemical burn of left hand, broken left leg, carpal tunnel syndrome.
- 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."
- Please give the exact address or location of injury (city, county, state, and zip).

SECTION 1 Completion of this section is required

Date employer notified and person y	Have you had prior problems or injuries to that part of the body? Yes No			
Witness(es) to the Injury	Address of Witness(es)			ore days from wor are han five days?
I understand and agree that North Dakota compensation ratating to work injuries, any release to WSI, its agents and attorneys, a refease any information or records about n any claim to my employer.	law determines all my rights and obligations to and fire to have enforcement or military against, any oversity and my and all information of the order of the color of a color by claim to third parties. If it is stress to the purpose of res	to mental health, alcohol, o	ovider or facility, any insurance comp i Security Administration, and any edu or drug abuse, and HIV/AIDS/AIDS re- serties. I authorize the release of any	lated illness. I authorize WSI
Worker's Signature	Date Signed	In addition to myse	if, I authorize WSI to release informat	ion on my claim to: (plaasse pr
1		First Name	Last Name	Relationship

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

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

Type of Injury (tracture, bruise; ci.t., etc.)						Date	of First Treatmen
Has the incident caused the worker to miss five or more days to Diagnosis condition based upon objective medical findings days work or is currently off work greater than five days to Diagnosis code: Yes No							
Has the worker ha	ad any prior proble	ms or injuries to that part	of the body?	1PLE	res, please provide	details	
Date worker may i	return to work:	☐ Without var	restrictions	□ With	the following restricts	ons (list)	
Date worker may	return to work	Please complete the	restrictions Physical Lifting	☐ With	the following restricts - see guide on rev		
Date worker may	Market and Admir	Please complete the	Physical Lifting	☐ With	the following restricts - see guide on rev 50 its		70 lbs
☐ Sedentary	10 lbs	Please complete the	20 ths	Demand Level below	– see guide on rev	ersa side.	
Sedentary Other instructions	10 lbs and/or limitations	Light including prescribed med	20 ths	Demand Level below	50 lbs sticipated length of m	erse side.	

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

- Please indicate if the incident will cause the worker to miss five or more days of work.
- 2 Please indicate the diagnosis condition based upon objective medical findings and the diagnosis code.
- 3 Please complete the Physical Lifting Demand Level see reverse side of First Report of Injury form for guide.
- **4** Please list other instructions and/or limitations including prescribed medications or physical therapy.
- **6** Please indicate the prognosis and anticipated length of medical treatment.

Employer Account Num	ber Worker's Rate Class	(See reverse)	OSHA Log Number (See reverse)		ident caused worker to miss five or n urrently off work greater than five da □ No			
	Is worker a corp. officer, owner, partner, spouse or child under age 22? Yes No		rt Time, II Sepsonel II	Temporary	First day worker lost wages due to work injury:	o 🗍 N/A		
Hourly Rate \$	Hours Worked Per Week	Gross Eagings ND	APT-	Joi 0	description submitted or attached? Yes No	account on a constant of the control		
Has the worker had any	prior problems or injuries to that	ent 2 the body	☐ Yes ☐ No	Da	le employer notified and person notifi	fied		
Do you have a Designal	led Medical Provider (DMP)?	If yes, did the worke	r opt out? Yes	□ No Da	te of Death (If applicable)			
If you question this cla	If you question this claim, state reason (continue on back) or attach additional information.							
Employer's Signature		Title		Da	te Signed			

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