WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		INSURED REPORT NUMBER		OSHA LOG NUMBER
		JURISDICTION	LOCATION #	PHONE #
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		FAX #
INDUSTRY CODE	EMPLOYER FEIN			EMAIL

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE, SUFFIX)	DATE OF BIRTH	LANGUAGE	DATE HIRED	STATE OF HIRE
ADDRESS (INCLUDE ZIP)	SEX • MALE • FEMALE • UNKNOWN	MARITAL STATUS • UNMARRIED/SINGLE/ DIVORCED • MARRIED • SEPARATED • UNKNOWN	OCCUPATION/JOB TITLE	
			EMPLOYMENT STATUS	
PHONE (HOME, CELL)	# OF DEPENDENTS		NCCI CLASS CODE	
EMAIL	EMPLOYEE ID	EMPLOYEE ID TYPE (SSN, GREEN CARD, PASSPORT)		
RATE PER: DAY WEEK MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? YES NO DID SALARY CONTINUE? YES NO		

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED AM PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	DATE EMPLOYER AWARE EMPLOYEE MISSING TIME DUE TO INJURY	MODIFIED DUTY AVAILABLE?
	DESCRIPTION OF INJURY/ILLNESS	DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL			
DATE RETURN(ED) TO WORK	PART-TIME OR FULL	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS/SAFETY EQUIPMENT PROVIDED? YES NO WERE THEY USED? YES NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT • NO MEDICAL TREATMENT • MINOR: BY EMPLOYER • MINOR CLINIC/HOSP • EMERGENCY CARE • HOSPITALIZED > 24 HOURS • FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED • OTHER
FOLLOW-UP CARE (NAME AND PHONE)	PROVIDER PANEL POSTED	TREATMENT WITH PANEL PROVIDER

OTHER

WITNESSES (NAME & PHONE #)
ADDITIONAL CLAIM INFORMATION/NOTES:
HAS EMPLOYEE SIGNED/DATED ACKNOWLEDGEMENT LETTER REGARDING WORKER'S COMPENSATION LAW, IF APPLICABLE?

NOTIFICATION ONLY?	DATE PREPARED	PREPARER'S NAME AND TITLE	PHONE NUMBER