TYPE OR PRINT FIRMLY - YOU ARE MAKING 4 COPIES

ALL COPIES OF FIRST REPORT MUST BE TYPED OR PRINTED

STATE OF DELAWARE
FIRST REPORT
OF
OCCUPATIONAL INJURY
OR DISEASE

Department of Labor
Office of Workers' Compensation
P.O. Box 8902
Wilmington, DE 19899-8902
Telephone 302-761-8200

CASE OR FILE NO.

EMPLOYERS UC REPORTING NUMBER

EMPLOYEE

1. EMPLOYEE: FIRST MIDDLE LAST			2. EMPLOYEE SOCIAL SECURITY NO.
a ADDRESS - INCLUDE COUNTY AND ZIP CODE		4. MALE ☐ FEMALE ☐	5. EMPLOYEE TELEPHONE NUMBER (INCLUDE AREA CODE)
6. DATE OF BIRTH	7. AGE	8. WAGE	9. WEEKLY HOURS WORKED
10. OCCUPATION (REGULAR)	11. DEPARTMENT OR DIVISION REGULARLY EMPLOYED		12. HOW LONG EMPLOYED

EMPLOYER

13. EMPLOYER	14. PERSON MAKING OUT THIS REPORT	
15. ADDRESS - INCLUDE COUNTY AND ZIP CODE		16. EMPLOYER TELEPHONE NUMBER (INCLUDE AREA CODE)
17. MAILING ADDRESS - IF DIFFERENT THAN ABOVE	18. NATURE OF BUSINESS - TYPE OF MFG., TRADE. CONSTRUCTION, SERVICE.. ETC.	

DATES

19. DATE OF REPORT	20. DATE OF INJURY AND TIME ☐ AM ☐ PM	21. NORMAL STARTING TIME ☐ AM ☐ PM	22. IF EMPLOYEE BACK TO WORK GIVE DATE:	23. AT SAME WAGE YES ☐ NO ☐
24. IF FATAL INJURY, GIVE DATE OF DEATH.	25. DATE EMPLOYER KNEW OF INJURY.	28. DATE DISABILITY BEGAN.	27. LAST FULL DAY PAID) - DATE	

INJURY OR DISEASE

28. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.

29. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.

OCCURRENCE

30. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE WAS USING WHEN THE INCIDENT OCCURRED, E.G ACETYLENE.

31. DESCRIBE THE EMPLOYEES ACTIVITY AT THE TIME OF INJURY OR ILLNESS, I.E.

32. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED.

33. NAME OF PHYSICIAN	34. PHYSICIAN'S ADDRESS
35. HOSPITAL (IF APPLICABLE)	38. HOSPITAL ADDRESS

WORKER'S COMPENSATION INSURANCE COMPANY AND COMPLETE ADDRESS (PREPRINT OR STAMP INCLUDE IAB CODE)

37. (THIS SECTION MUST BE COMPLETED IN ORDER TO PROCESS.)

POLICY NO.

DISTRIBUTION OF THIS REPORT

1. ORIGINAL MUST BE SENT IMMEDIATELY TO WORKER'S COMPENSATION INSURANCE CARRIER.

2. COPY TO THE INDUSTRIAL ACCIDENT BOARD

3. EMPLOYER'S COPY - RETAIN AS RECORD

4. EMPLOYEE'S COPY

SIGNATURE OF PERSON IN 14 ABOVE

OFFICIAL POSITION

WORKERS' COMPENSATION

IMPORTANT THINGS TO DO IN CASE OF INJURY

THE EMPLOYER SHOULD:

1. Provide all necessary medical, surgical and hospital treatment from the date of accident.

2. Every employer shall keep a record of all injuries received by employees and make a report within 1 0 days thereof in writing to the Office of Workers' Compensation.

3. Ascertain the average weekly wages of the employee and provide compensation in accordance with the provisions of the law, for disability *beyond the third day* after the accident. All agreements as to compensation must be submitted to the Office of Workers' Compensation for approval.

THE EMPLOYEE SHOULD:

1. Immediately notify the employer in writing of accidental injury or occupational disease and request medical services. Failure to give notice or to accept medical services may deprive the employee of the right to compensation.

2. Give promptly to the employer, directly or through a supervisor, notice of any claim for compensation for the period of disability beyond the third day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person on their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the law, file application with the Industrial Accident Board for a hearing on the matters at issue within two years of the date of accidental injury or one year of knowledge of the diagnosis of an occupational disease or an ionizing radiation injury. All forms can be obtained from the Office of Workers' Compensation.