

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/Administrator CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE	
		JURISDICTION		JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER			
INDUSTRY CODE		EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
				LOCATION #	
				PHONE #	
CARRIER/CLAIMS ADMINISTRATOR					
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)		
		TO			
		CHECK IF APPROPRIATE			
		<input type="checkbox"/> SELF INSURANCE			
CARRIER FEIN	POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN		
AGENT NAME & CODE NUMBER					
EMPLOYEE/WAGE					
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS		OCCUPATION/JOB TITLE
		<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN	<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN	EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE		
RATE PER:	<input type="checkbox"/> DAY WEEK	<input type="checkbox"/> MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
OCCURRENCE/TREATMENT					
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE () CANNOT BE DETERMINED	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED	
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE	
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					CAUSE OF INJURY CODE
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT	
				0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
OTHER					
WITNESSES (NAME & PHONE #)					
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER