



EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE EMPLOYER IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.

INSTRUCTIONS AND CODES ON THE REVERSE SIDE - Please Print Legibly or Type - Unreadable forms will be returned.

E M P L O Y E E	1. Employee's Name (Last, First, MI):		2. Home Telephone Number:		3. Social Security Number*:		4. Sex: ☐ M ☐ F	
	5. Home Address (No., Street, City, State & Zip Code):				5a. Native Language Code: Other: _____		6. Marital Status: ☐ M ☐ S	
	7. No. of Dependents:		8. Date of Hire (mm/dd/yyyy):		9. Date of Birth (mm/dd/yyyy):		10. Average Weekly Wage: \$ ☐ Estimated ☐ Actual	
E M P L O Y E R	11. Employer's Name:				12. Federal Tax ID Number:			
	13. Employer's Address (No., Street, City, State & Zip Code):				14. Employer's Telephone Number:			
	15. Industry Code (See Reverse Side):				16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR):			
	17. W.C. Policy Number:				18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number: _____			
I N J U R Y I N F O R M A T I O N	19. Business Type: ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other _____				20a. Insurer's Case/Claim File No.:			
	20. DATE OF INJURY (mm/dd/yyyy):							
	21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No				22. Location of Injury if not on Employer's Premises:			
	23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):				24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):			
	25. If Employee has Died, Date of Death (mm/dd/yyyy):				26. Source of Injury (Chemicals, Machinery, etc.):			
	27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:							
P R E P A R E R	28. Person to Whom Injury was Reported (list position):				29. Date Reported (mm/dd/yyyy):		30. Date Reported as work related (mm/dd/yyyy):	
	31. Injury Code(s) a. _____ to body part _____ b. _____ to body part _____ c. _____ to body part _____		Body Part Code(s) a. _____ b. _____ c. _____		32. Witnesses to Injury - Give Full Name(s), if none state as such:			
	33. Has Employee Returned to Work? ☐ Yes ☐ No				34. Date Employee Returned to Work (mm/dd/yyyy):			
	35. Employer's Regular Occupation:				36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No			
	37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):				38. PREPARER'S Title:			
39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):				40. Date Prepared (mm/dd/yyyy):		40a. PREPARER'S e-mail address:		

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report.

Form 101 - Revised 7/2010 - Reproduce as needed.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

First Report Of Injury Form

Sebastian Brünink

A red circular graphic with a gradient, appearing as a stylized arrow or a partial circle, located to the right of the name bar.

First Report Of Injury Form:

First Report Of Injury Form Book Review: Unveiling the Magic of Language

In an electronic era where connections and knowledge reign supreme, the enchanting power of language has are more apparent than ever. Its capability to stir emotions, provoke thought, and instigate transformation is really remarkable. This extraordinary book, aptly titled "**First Report Of Injury Form**," written by a very acclaimed author, immerses readers in a captivating exploration of the significance of language and its profound impact on our existence. Throughout this critique, we shall delve to the book is central themes, evaluate its unique writing style, and assess its overall influence on its readership.

https://staging.conocer.cide.edu/files/publication/Documents/Eddie_Called_Me_Boss.pdf

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