

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

General	Employer (Name & Address incl. zip)				Carrier Administrator Claim Number				Report Purpose Code							
					Jurisdiction		Jurisdiction Claim Number									
					Insured Report Number											
					Employer's Location Address (if different)						Location No.					
	Sic Code		Employer FEIN		Phone No.											
Carrier/Claims Admin	Carrier (Name, Address & Phone Number)				Policy Period		Claims Admin (Name, Address & Phone Number)									
					to											
					<input type="checkbox"/> Check if self insured											
					Carrier FEIN		Policy Number or Self-Insured Number				Administrator FEIN					
Agent Name & Code Number																
Employee/Injured	Legal 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"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		<input type="checkbox"/> Unmarried/Single/Div. <input type="checkbox"/> Married <input type="checkbox"/> Separated									
					Employment Status											
	Phone				No. of Dependents		Unknown		NCCI Class Code							
	Wage Rate		<input type="checkbox"/> Day <input type="checkbox"/> Week		<input type="checkbox"/> Month <input type="checkbox"/> Other		<input type="checkbox"/> if days worked/week <input type="checkbox"/> if hrs worked per day		Full Pay for Date of		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Did Salary Continue?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Occurrence	Time Employee Began Work		<input type="checkbox"/> A <input type="checkbox"/> P		Date of Injury or Illness		Time Occurred		<input type="checkbox"/> A <input type="checkbox"/> P		Last Work Date		Date Employer Notified		Date Disability Began	
	Employer Contact Name/Phone Number								Type of Illness/Injury				Part of Body Affected			
	Did Injury/Illness Exposure Occur on Employer's Premises?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Type of Illness/Injury 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 Returned to				if Fatal, 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	
	Were they used?				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Treatment	Physician/Health Care Provider (Name & Address)				Hospital (Name & Address)				Initial Treatment 0 <input type="checkbox"/> No Medical Treatment 1 <input type="checkbox"/> Minor: By Employer 2 <input type="checkbox"/> Minor Clinic/Hosp 3 <input type="checkbox"/> Emergency Care 4 <input type="checkbox"/> Hospitalized > 24 hr. 5 <input type="checkbox"/> Future Major Medical/Lost Time Anticipated						
		Witness to Accident (Name & Phone Number)														
Other	Date Administrator Notified				Date Prepared		Preparer's Name & Title				Preparer's Phone Number					
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DP Hallahan



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