WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCLUDING ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION # (IF AVAILABLE)
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE #)	POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE #)
	CHECK IF APPROPRIATE: SELF-INSURANCE	

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SEC. # (IF THERE IS ONE)	DATE HIRED	STATE OF HIRE

ADDRESS (INCLUDING ZIP)	SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE
			EMPLOYMENT STATUS
PHONE #	# OF DEPENDENTS		NCCI CLASS CODE

RATE PER: DAY / MONTH / WEEK / 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 AM PM CANNOT BE DETERMINED	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? YES 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 RETURNED TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR 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/HOSPITAL EMERGENCY CARE HOSPITALIZED > 24 HOURS FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

WITNESS(ES) NAME(S) & PHONE #(S)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER