# Workers' Compensation - First Report of Injury or Illness

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|---|---|---|---|---|---|
| Employer (Name, Address & Phone) | | | Carrier/Administrator Claim Number | | Report Purpose Code |
| Jurisdiction | | | Jurisdiction Claim Number | | |
| Nature of Business | | | Insured Report Number | | |
| SIC Code | Employer FEIN | | Employee Location Address & Phone (if different) | | |
| Fax # | Location # | | | | |
| **Carrier/Claims Administrator** | | | | | |
| Carrier (Name, Address, & Phone) | | | Policy Period | | Self Insured (Yes/No) |
| Claims Administrator (Name, Address & Phone) | | | | | |
| 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 | | Sex | Marital Status | Occupation/Job Title | NCCI Class Code |
| Employment Status | | | | | |
| Phone | | | Number of Dependents | | |
| Rate | Per | # of Days Worked/ Week | # of Hours per Day | # of Hours Worked per Week | |
| **Full Pay for Day of Injury?** | | | **Did Salary Continue?** | | |
| **Occurrence/Treatment** | | | | | |
| Time Employee Began Work | Date of Injury | | Time of Occurrence | Last Work Date | |
| Date Employer Notified? | Date Admin Notified | | Did employee work the next day? | | |
| Date Employee Failed to Work Full Day | | | Does the Employer agree with the description of accident? | | |
| Did injury/illness occur on employer's premises? | Type of injury/illness | | | Part of body affected | |
| Location where accident or illness exposure occurred (company, address, county, phone) | | | 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 the accident 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 | Has employee returned to work (date): | |
| | | | | If fatal, give date of death: | |
| Were safeguards or safety equipment provided? | Were they used? | | | Initial Treatment | |
| Physician/Health Care Provider (Name & Address) | | | Hospital (Name, Address, & Phone) | | |
| Witness (Name & Phone) | | | | Lost time injury? | |
| Name of caller: | | | Title: | Phone Number: | |

SUBMIT