Workers' Compensation - First Report of Injury or Illness

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