



Employers First Report of Injury or Illness

Claim#: _____

Carrier's Claim#: _____

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

1. Name (Last, First, M.I.): _____

2. Sex: F M

3. Social Security Number: _____

4. Home Phone: (____) _____ - _____

5. Date of Birth (m-d-y): ____ - ____ - ____

6. Does Employee Speak English? YES NO

If No, Specify Language: _____

7. Race: White Black Asian

8. Ethnicity: Hispanic Native American Other

9. Mailing Address:

Street or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

County: _____

10. Marital Status: Married Widowed Separated

Single Divorced

11. No. of Dependent Children: _____

12. Spouse's Name: _____

13. Doctor's Name: _____

14. Doctor's Mailing Address:

Street or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

15. Date of Injury (m-d-y): ____ - ____ - ____

16. Time of Injury: ____ : ____ am pm

17. Date Lost Time Began (m-d-y): ____ - ____ - ____

18. Nature of Injury*: _____

19. Part of Body Injured or Exposed*: _____

20. How and Why Injury/Illness Occurred*: _____

21. Was Employee Doing His/Her Regular Job? YES NO

22. Worksite Location of Injury (stairs, dock etc.): _____

23. Address Where Injury or Exposure Occurred/

Business Name (if applicable): _____

Street or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

County: _____

24. Cause of Injury (fall, tool, machine etc.): _____

25. List Witnesses: _____

26. Expected Return to Work (m-d-y): ____ - ____ - ____

27. Did Employee Die? YES NO

28. Supervisor's Name: _____

29. Date Reported (m-d-y): ____ - ____ - ____

30. Date of Hire (m-d-y): ____ - ____ - ____

31. Was Employee Hired or Recruited in Your State?

YES NO

32. Length of Service in Current Position:

Months: ____ Years: ____

33. Length of Service in Occupation:

Months: ____ Years: ____

34. Employee Payroll Classification Code: _____

35. Occupation of Injured Worker: _____

36. Rate of Pay at This Job: \$ ____ Hourly, \$ ____ Weekly

37. Full Work Week is: ____ Hours, ____ Days

38. Last Paycheck Was: \$ ____ for ____ Hours or ____ Days

39. Is Employee an Owner, Partner or Corporate Officer?

YES NO

40. Name and Title of Person Completing Form:

41. Name of Business: _____

42. Business Mailing Address and Phone Number:

Street or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ - _____

43. Business Location (if different from mailing address):

Number and Street: _____

City: _____ State: _____ Zip Code: _____

44. Federal Tax Identification Number: _____

45. Primary North American Industry Classification System Code (6 digit): _____

46. Specific NAICS Code (6 digit): _____

47. State Comptroller Taxpayer No.: _____

48. Workers Compensation Insurance Company: _____

49. Policy Number: _____

50. Did You Request Accident Prevention Services in the Past 12 Months? YES NO

If Yes, Did You Receive Them? YES NO

51. Signature and Title:

X _____

Date: _____