EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS
2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO
3. ☐ LOST EARNINGS BUT NO LOST TIME
4. ☐ MEDICAL/HEALTH CARE
5. ☐ FATALITY DATE OF DEATH: ___/___/___ MM DD YYYY
6a. ☐ OCCUPATIONAL DISEASE
6b. DATE OF LAST EXPOSURE: ___/___/___ MM DD YYYY
6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ___/___/___ MM DD YYYY
7a. ☐ CORRECT PRIOR REPORT
7b. DATE OF CORRECTION: ___/___/___ MM DD YYYY
7c. DATE CORRECTION SENT TO WCB: ___/___/___ MM DD YYYY

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):	10. EMPLOYER NAME:		
11. STREET/P O BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:	21. INSURER FILE NUMBER:		
22. STREET/P O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER: ( )

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER:	32. GENDER: ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:	35. STATE:	36. ZIP:	37. DATE OF BIRTH: ___/___/___ MM DD YYYY	
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE: ___/___/___ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $	41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐YES ☐ NO IF YES, GIVE NAME AND ADDRESS:		

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ___/___/___ MM DD YYYY	43. DATE OF INCAPACITY: ___/___/___ MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ___/___/___ MM DD YYYY
DATE EMPLOYER NOTIFIED: ___/___/___ MM DD YYYY	DATE EMPLOYER NOTIFIED: ___/___/___ MM DD YYYY	46. TIME OF INJURY (e.g. 1:10 p.m.):	47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE: ___/___/___ MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART (s) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO	54. HEALTH CARE PROVIDER NAME:	55. MAILING ADDRESS:	56. TELEPHONE NUMBER: ( )

PREPARER INFORMATION

57. PREPARER NAME AND TITLE (TYPE OR PRINT):	58. TELEPHONE NUMBER: ( )	59. DATE SENT TO WCB: ___/___/___ MM DD YYYY

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