☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE, OR FATALITY

Insurer File No.

1. EMPLOYER LOCATION:	**2. EMPLOYER NAMED ON WC INSURANCE POLICY:** ☐ **SAME AS BLOCK 1**
FEIN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone/Ext. Type of Business	Phone/ Ext.
	WC Policy Number

3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone/ Ext.	Phone/ Ext.

5. EMPLOYEE INFORMATION:		**6. MEDICAL INFORMATION:**
SSN ☐ Male ☐ Female		Treatment Facility
Name		Address
Address		City, State, Zip
City, State, Zip		Phone/ Ext.
Phone	Date of Birth	**7. WITNESS INFORMATION:**
Occupation	Date Hired	Name & Phone:
State of Hire	Preferred Language of Employee: ☐ English ☐ Spanish ☐ Portuguese ☐ Other	

8. INJURY INFORMATION:	What was person doing when injured?
Injury Date	
Time injury occurred ☐ AM ☐ PM	
Time employee began work ☐ AM ☐ PM	
1. First full day lost from work ☐ NONE LOST	
2. Date returned to work (if appropriate)	List injured body parts and nature of injury: (ex: Broken left finger, lower back strain)
3. Date employer notified of injury	
If fatal - **REPORT WITHIN 48 HOURS** - Date of death	
Place where injury/illness occurred: ☐ At employer location listed in Block 1 **OR**	Complete address where accident occurred:
Was this injury previously an incident-only with no medical treatment and no time lost? ☐ Yes ☐ No	
If Yes, date employer first notified of medical treatment or time lost	
Category(ies) of injury or illness: ☐ Injury ☐ Illness ☐ Occupational Disease ☐ Repetitive Trauma ☐ Occupational Hearing Loss ☐ Unknown	

Print Name of Report Preparer	Date Prepared	Phone & Extension
Print Name of Employer Contact Person OR ☐ Same as above		Phone & Extension