EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

INJURED WORKER INFORMATION:

Name:	Phone:
Address:	City: State: Zip:
Social Security Number:	Date of Birth:
Marital Status:	Sex: Male ☐ Female ☐ Unknown ☐
Occupation / Job Title:	Date Hired:
Employment Status:	Number of Dependents:
Wage: Wage Period:	Daily ☐ Weekly ☐ Monthly ☐
Full Pay for Day of Injury: Yes ☐ No ☐	Number of Days Worked per Week:

EMPLOYER INFORMATION:

Business Name:	Phone:
Employer Contact:	Phone:
Mailing Address:	City: State: Zip:
Employment Address:	City: State: Zip:
Employer FEIN:	

INSURANCE INFORMATION:

Carrier:	Phone:
Carrier Address:	City: State: Zip:
Policy / Self-Insured Number:	Policy Period:

OCCURRENCE/TREATMENT:

Date of Injury / Disease:	Time of Injury:	Date Employer Notified:
Nature:	Body Part:	Cause:
Last Day Worked:	Date Disability Began:	Date Returned to Work:
Fatality: Yes ☐ No ☐	Date of Death:	Date Administrator Notified:

Address of Occurrence: City: State: Zip:

Premises: Employer's ☐ Other ☐ Description:

Accident Description:

Provider Injured Worker Received Care From:

Provider Address : City: State: Zip:

Treating Physician: Phone:

Initial Treatment: No Medical Treatment ☐ Minor: By Employer ☐ Minor: Clinic/Hospital ☐ Emergency Care ☐
Hospitalized- 24 Hours ☐ Future Major Medical/Lost Time Anticipated ☐

Witnesses: Yes ☐ No ☐ If yes list their names and phone number: