

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

Employer (Name & Address Including Zip)		Carrier/Administration Claim Number		Report Purpose Code	
		Jurisdiction		Jurisdiction Claim Number	
		Insured Report Number KY			
		Employer's Location Address (if different)			Location #
SIC Code	Employer FEIN			Phone #	

**EMPLOYER'S INSTRUCTIONS  
DO NOT ENTER DATA IN SHADED FIELDS**

**DATES:**

Enter all dates in MM/DD/YY.

**SIC CODE:**

This is the code that represents the nature of the employer's business that is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

**CARRIER:**

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer or the claimant.

**CLAIMS ADMINISTRATOR:**

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

**AGENT NAME & CODE NUMBER:**

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

**OCCUPATION/JOB TITLE:**

This is the primary occupation of the claimant at the time of the accident or exposure.

**EMPLOYMENT STATUS:**

Indicate the employee's work status. The valid choices are: Full-Time, Not Employed, Disabled, Unknown, Apprenticeship Part-Time, Seasonal, Part-Time, On Strike, Retired, Apprenticeship Full-Time, Volunteer, and Piece Worker.

**DATE DISABILITY BEGAN:**

The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise designated by the statute.

**CONTACT NAME/PHONE NUMBER:**

Enter the name of the individual at the employer's premises to be contacted for additional information.

**TYPE OF INJURY/ILLNESS:**

Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

**PART OF BODY AFFECTED:**

Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

**DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210) If the accident or illness exposure did not occur on the employer's premises, enter the address or location. Be specific.

**ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

(e.g., Acetylene cutting torch, metal plate)

List all equipment, materials and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

**SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

(e.g., Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation of painting.

**WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:**

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

**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:**

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

**DATE RETURN(ED) TO WORK:** Enter the date following the most recent disability period on which the employee returned to work.

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Employee Signature: \_\_\_\_\_

DATE: \_\_\_\_\_