

# EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):
1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)		
2a. <input type="checkbox"/> LOST TIME - ONE OR MORE DAYS	2b. WAS EMPLOYEE PAID FOR 1/2 DAY OR MORE ON DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. <input type="checkbox"/> LOST EARNINGS BUT NO LOST TIME	4. <input type="checkbox"/> MEDICAL/HEALTH CARE	5. <input type="checkbox"/> FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY
6a. <input type="checkbox"/> OCCUPATIONAL DISEASE	6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY	6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY
7a. <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one) <input type="checkbox"/> INSURER <input type="checkbox"/> THIRD PARTY ADMINISTRATOR (TPA) <input type="checkbox"/> 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: <input type="checkbox"/> MALE <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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):
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51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring):	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.):
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53. HOSPITALIZED OVERNIGHT AS INPATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO	55. HEALTH CARE PROVIDER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )
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PREPARER INFORMATION		
58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ____/____/____ MM DD YYYY

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