# 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. ☐ LOST TIME - ONE OR MORE DAYS

2b. WAS EMPLOYEE PAID FOR 1/2 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
DATE EMPLOYER NOTIFIED:
MM DD YYYY

43. DATE OF INCAPACITY:
MM DD YYYY
DATE EMPLOYER NOTIFIED:
MM DD YYYY

44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):

45. DATE EMPLOYER NOTIFIED INSURER/TPA:
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. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM?
☐ YES ☐ NO

55. HEALTH CARE PROVIDER NAME:

56. MAILING ADDRESS:

57. TELEPHONE NUMBER:

**PREPARER INFORMATION**

58. PREPARER NAME AND TITLE (TYPE OF PRINT):

59. TELEPHONE NUMBER:
( )

60. DATE SENT TO WCB:
_____/_____/_____ MM DD YYYY

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