



Indiana Worker's Compensation First Report of Employee Injury/Illness

Please Return Completed Form to: 402 W. Washington St., Room W196
Indianapolis, IN 46204-2753
(317) 232-3808

FOR WORKER'S COMPENSATION BOARD USE ONLY		
JURISDICTION	JURISDICTION CLAIM NUMBER	PROCESS DATE

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	OCCUPATION/JOB TITLE	NCCI CLASS CODE
LAST NAME	FIRST	MIDDLE	MARITAL STATUS <input type="checkbox"/> UNMARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	DATE HIRED
ADDRESS (INCL ZIP)			STATE OF HIRE	EMPLOYEE STATUS
PHONE	NO. OF DEPENDENTS	WAGE \$	PER <input type="checkbox"/> HR <input type="checkbox"/> DAY <input type="checkbox"/> WK <input type="checkbox"/> MO <input type="checkbox"/> YR <input type="checkbox"/> OTHER	PAID DAY OF INJ <input type="checkbox"/> SALARY CONT'D <input type="checkbox"/>
		HRS/DAY	DAYS/WK	AVG WG/WK

EMPLOYER INFORMATION

EMPLOYER (NAME, ADDRESS, CITY, STATE, ZIP)	EMPLOYER FEDERAL ID NO.	SIC CODE	INSURED REPORT NUMBER
	LOCATION NO.	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
	PHONE NO.		
	CARRIER/ADMINISTRATOR CLAIM NUMBER	REPORT PURPOSE CODE	

Actual Location of Accident/Exposure (if not on employer's premises):

CARRIER/CLAIMS ADMINISTRATOR INFORMATION

CLAIMS ADMINISTRATOR (NAME, ADDRESS, PHONE NO.)	CARRIER FEDERAL ID NO.	CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE
PHONE:	<input type="checkbox"/> INSURANCE CARRIER <input type="checkbox"/> THIRD PARTY ADMIN	POLICY/SELF-INSURED NUMBER
AGENT NAME	CODE NUMBER	POLICY PERIOD FROM TO

OCCURRENCE/TREATMENT INFORMATION

DATE OF INJ/EXP	TIME OF OCCURRENCE ___ M	DATE EMPLOYER NOTIFIED	TYPE OF INJURY/EXPOSURE	TYPE CODE
LAST WORK DATE	TIME WORKDAY BEGAN	DATE DISABILITY BEGAN	PART OF BODY	PART CODE
RTW DATE	DATE OF DEATH	INJURY/EXPOSURE OCCURRED ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	CONTACT NAME	PHONE NUMBER
DEPARTMENT OR LOCATION WHERE ACCIDENT/EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS INVOLVED IN ACCIDENT		
SPECIFIC ACTIVITY ENGAGED IN DURING ACCIDENT/EXPOSURE		WORK PROCESS EMPLOYEE ENGAGED IN DURING ACCIDENT/EXPOSURE		
HOW INJURY/EXPOSURE OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY RELEVANT OBJECTS OR SUBSTANCES				CAUSE OF INJURY CODE
NAME OF PHYSICIAN/HEALTH CARE PROVIDER			INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR: CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
WITNESSES (NAME, PHONE NO.)		DATE ADMINISTRATOR NOTIFIED		
DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER	

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13)