WORKERS' COMPENSATION

FIRST REPORT OF CLAIM

Name of Person Reporting:______________________ Telephone:______________

ADDRESS INFORMATION

Name of the Company:____

Address of the Company:______________________

____

Contact Name:______________________

Telephone Number of Loss Location:______________________

Site Code (if applicable):______________________

ACCIDENT INFORMATION

Date and Time of Accident: ____/____/____ __________ ☐ am ☐ pm

Address where Accident Occurred:______________________

____

Description of the Incident:

Were Authorities Contacted? (i.e. Police, Fire, Ambulance) ☐ Yes ☐ No

If Yes, who?____

Was a Report Number given? ☐ Yes ☐ No

If Yes, list number:____

Were any Safeguards provided? ☐ Yes ☐ No Were they in use at the Time of the Accident? ☐ Yes ☐ No

In the event of a Fatality, what is your OSHA number?______________________

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FIRST REPORT OF CLAIM

CLAIMANT INFORMATION

Name of the Injured Party:______________________ Is the Injured Party: ☐ Male ☐ Female

Address of the Injured Party:______________________

____

Home Telephone:______________________ Work Telephone:______________________

Social Security:______________________ Date of Birth:______________________

Covered by Other insurance: ☐ Yes ☐ No If Yes, Company Name:______________________

Marital Status: (check one) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Dependents:______________ If Fatality, what Date did it occur?______________

Regular Occupation:______________________ Occupation at Time of Incident:______________

EMPLOYMENT INFORMATION

Employment Status: (check one)
☐ Full-time ☐ Part-time ☐ Temporary ☐ Seasonal ☐ Contract ☐ Retired ☐ On-Call ☐ Volunteer

Date of Hire: ____/____/____ Hours Worked per Day:__________ Days Worked per Week:__________

Was there Lost Time? ☐ Yes ☐ No Paid through Date:____/____/____

Supervisor Name:______________________ Telephone:______________________

Eligible for Salary Continuation? (Sick Leave, Short-term Disability) ☐ Yes ☐ No

Date Disability Began: ____/____/____ Last Day Worked:____/____/____ Date Returned to Work:____/____/____

Weeks Worked in last Twelve Months:______________ Date Employer Notified:______________

Hourly or Weekly Wage: $__________ ☐ Hourly ☐ Weekly

Wage Listed: ☐ Bonus ☐ Tip ☐ Overtime ☐ Commissions

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FIRST REPORT OF CLAIM

INJURY INFORMATION

Were any injuries incurred? ☐ Yes ☐ No What part of the body?______________________________

Give a description of the injuries:

What treatment was given? (please check) ☐ No Medical Treatment ☐ Minor On-Site Remedies
☐ Minor Clinic or Hospital ☐ Emergency Evaluation ☐ Hospitalization for more than 24 Hours

Name of the Treating Physician:______________________________

Address of the Treating Physician: ______________________________

____

Telephone Number of Treating Physician:______________________________

Name of the Treating Hospital/Clinic:______________________________

Address of the Treating Hospital/Clinic:______________________________

____

Telephone Number of the Treating Hospital/Clinic:______________________________

WITNESS INFORMATION

Name of a Witness to the Incident:______________________________

Address of the Witness:______________________________

____

Telephone Number where the Witness can be Reached:______________________________

WORKERS' COMPENSATION

FIRST REPORT OF CLAIM

CARRIER INFORMATION

Name of Carrier:____

Policy Number:____________________ Policy Inception/Expiration:____________________

Write or type below anything related to the incident you would like to add.