EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS UNLESS APPROPRIATE

DATES:
Enter all dates in MM/DD/YY format. Enter all time in HH:MM format (e.g. 06:05)

INDUSTRY CODE:
This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, 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 of 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	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by 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, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(eg. 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 address or location. Be specific.

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EMPLOYER'S INSTRUCTIONS – cont'd

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

(eg. Acetylene cutting torch, metal plate)

List all of the 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:

(eg. 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 for 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 (eg. 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 to most recent disability period on which the employee returned to work.

DATE OF DEATH (if applicable)

This is a required field. Enter the date of death, if applicable.

TYPE OF INJURY/ILLNESS CODE

This is a required filed. Enter the two-digit code that corresponds to the type of injury/illness. A list of codes can be found at:

INITIAL TREATMENT

This is a required field. Select the item that corresponds to the initial treatment.

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WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Name
Address
City State
Zip
INDUSTRY CODE
EMPLOYER FEIN

CARRIER/ADMINISTRATOR CLAIM
OSHA LOG
REPORT PURPOSE
JURISDICTION
JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
LOCATION #
Address
PHONE #
City State Zip

CARRIER (NAME, ADDRESS, & PHONE #)
Name
Address
City State
Zip Phone
CARRIER FEIN
POLICY/SELF-INSURED NUMBER

POLICY PERIOD
TO
CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Name
Address
City State
Zip Phone
ADMINISTRATOR FEIN

EMPLOYEE Last Name Middle
First Name
Address
City State
Zip Phone
OF DEPENDENTS

DATE OF BIRTH
SOCIAL SECURITY
DATE HIRED
STATE OF HIRE
SEX
○ Male
○ Female
○ Unknown
MARITAL STATUS
○ Unmarried Single/Divorced
○ Married
○ Separated
○ Unknown
OCCUPATION/JOB TITLE
EMPLOYMENT STATUS
NCCI CLASS CODE

WAGE
RATE PER: ○ Day ○ Week ○ Month ○ Other
DAYS WORKED/WEEK
FULL PAY FOR DAY OF INJURY? ○ Yes ○ No
DID SALARY CONTINUE? ○ Yes ○ No

TIME EMPLOYEE BEGAN ○ AM ○ PM
DATE OF INJURY/ILLNESS
TIME OF OCCURRENCE ○ AM ○ PM ○ Unknown
LAST WORK DATE
DATE EMPLOYER NOTIFIED
DATE DISABILITY BEGAN

CONTACT NAME
CONTACT PHONE
TYPE OF INJURY/ILLNESS
PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?
○ Yes ○ No
TYPE OF INJURY/ILLNESS CODE
PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE
ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

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
CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK
IF FATAL, GIVE DATE OF DEATH
WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ○ Yes ○ No
WERE THEY USED? ○ Yes ○ No

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)
Name
Address
City State

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)
Name
Address
City State

INITIAL TREATMENT
○ NO MEDICAL TREATMENT
○ MINOR BY EMPLOYER
○ MINOR CLINIC/HOSP
○ EMERGENCY CARE
○ HOSPITALIZED > 24 HOURS
○ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESS NAME
PHONE
ADMINISTRATOR NOTIFIED
DATE PREPARED
PREPARER'S NAME & TITLE
PHONE NUMBER
PREPARER'S EMAIL ID:

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