



P.O. Box 1029, FOND DU LAC, WI 54936-1029
 PHONE (888) 576-2438 • FAX (920) 922-1071

First Report of Injury

Insured

Name			
Address			
Phone number	Fax number	E-mail address	
Location code of employer		Doing business as (if different)	
Type of business	FEIN	Unemployment insurance number	SIC code

Employer

Name	
Address	Phone number
E-mail address	Fax number
Doing business as (if different)	FEIN

Carrier

Worker's compensation carrier name	Unit number	FEIN
Address	Policy number	

Employee

Name (first, middle, last, suffix)		Date of birth	
Address		Social Security number	
Occupation/job title	Phone	Cell phone	
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Number of dependents	Date hired
Employment status (full time, part time, season, piece work, other)		Employment shift (first shift, second shift, third shift, etc.)	

Incident description

Did the incident occur on the employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Time employee began work (include a.m. or p.m.)	Date of injury/illness	Time of incident (include a.m. or p.m.)
Last work date	Date employer notified	Injury reported to	Phone number
Date returned to work	Estimated date of return to work	Type of injury/illness	Part of body affected
Department and location where the incident occurred (include county, state, and zip code)			
Responding police department		Fell from height of (ft)	Lifting of moving weight (lbs)
List all equipment, materials, or chemicals the employee was using when the incident occurred			
Specific activity the employee was engaged in when the incident occurred			
Explain how the injury/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			
If fatal, indicate date of death.	Were safeguards or safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were safeguards used? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the incident involve failure to obey rules? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did the incident involve alcohol or substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have mandatory drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was drug testing performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was alcohol testing performed? <input type="checkbox"/> Yes <input type="checkbox"/> No

Employee wages

Pay rate	Per (hour, day, week, month, etc.)	Employee's usual start time	Employee's usual hours per day	Employee's usual hours per week
Employee's usual days per week	Does employee work overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is overtime regular and mandatory? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does employee earn tips? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does employee earn other wages? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the employee work another job? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where?		Full wages paid for date of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was salary continued? <input type="checkbox"/> Yes <input type="checkbox"/> No
In the 52-week period prior to the incident, how many weeks did the employee do the same kind of work?		If piece work was involved, how many hours (excluding overtime) did the employee perform the same kind of work in the 52-week period prior to the incident?		
In the 52-week period prior to the incident, what was the gross amount of total wages, salary, overtime, tips, commission, and bonus premium earned for the same kind of work?				
Number of full-time employees doing the same type of work		Are any part-time workers doing same work/same schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many?	

Medical treatment

Physician or healthcare provider name	Physician or healthcare provider address
Hospital or off-site treatment name	Hospital or off-site treatment address
Initial treatment <input type="checkbox"/> No medical treatment <input type="checkbox"/> Emergency care	<input type="checkbox"/> Minor by employer <input type="checkbox"/> Hospitalized > 24 hours <input type="checkbox"/> Minor by clinic/hospital <input type="checkbox"/> Future major medical/lost time anticipated

Witness information

Witness name	Phone
Witness name	Phone

Date administrator notified	Date prepared
Preparer name/title	Preparer phone

Employer's instructions

We don't recommend completing the First Report of Injury for lost-time claims, claims with the potential for lost time, claims with complex medical issues, claims with debatable facts, or claims with potential third-party involvement.

If your claim involves any of the above issues, please telephone your claim information to us directly at 888-576-2438.

General Instructions

Completion of fields:

Complete as much of the requested information as possible. Do not leave fields blank. If the requested information does not apply to the incident, please indicate N/A.

Dates:

Enter all dates in the "MM/DD/YY" format (for example, 10/15/07).

Employer section

Location code of employer:

If the employer has multiple locations, enter the code for the location where the incident occurred.

Type of business:

The type of business that you, the employer, are engaged in.

FEIN:

Your Federal Employee Identification Number. If necessary, please reference your tax records for this information.

Unemployment insurance number (required for all Iowa claims):

Please refer to the packet of information that you received from your state agency that addresses unemployment benefits for your employees.

SIC code (required for all Illinois and Iowa claims):

Your Standard Industrial Class Code. This is the code that represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

Employee name section

Occupation/job title:

This is the primary occupation of the injured worker at the time of the incident.

Employee wages section

52 week wage information:

Indicate the both the number of weeks worked and the amount of gross wages (including overtime, tips, etc.) earned in the 52 weeks just prior to the incident. It is helpful to us if the wage information is broken out on a week-by-week basis on a separate sheet of paper and forwarded to us with the First Report of Injury.

Incident description section

Injury reported to/phone number:

Enter the name of the individual at the employer's premises to be contacted for additional information if the incident was reported to someone other than the preparer of the First Report of Injury.

Date returned to work:

Enter the date following the most recent disability period that the employee returned to work.

Estimated date of return to work:

Enter the estimated date that the employee will return to work based the information received from the employee or the medical providers.

Type of injury/illness:

Briefly describe the nature of the injury or illness (for example, lacerations to the forearm).

Part of body affected:

Indicate the part of body affected by the injury/illness (for example, right forearm or lower back).

Department or location where the incident occurred:

If the incident did not occur on the employer's premises, enter address or location. Please include the county and state where the incident occurred. For example: Maintenance Department on employer's premises or client's office at 150 Camelot Dr., Fond du Lac, WI 54935 (Fond du Lac County).

List all equipment, materials, or chemicals the employee was using when the incident occurred:

List all of the equipment, materials, or chemicals the employee was using, applying, handling, or operating when the incident occurred. Be specific. For example: scaffolding, electric sander, floor cleaner, box cutters, paintbrush, paint, etc. Enter "N/A" for not applicable if no equipment or materials 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 incident occurred:

Describe the specific activity the employee was engaged in when the incident occurred, such as sanding ceiling woodwork in preparation for painting or cutting carpeting to be installed.

Explain how the injury/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:

Describe how the injury, illness, or abnormal health condition occurred. Include the sequence of events and name any objects or substances 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.