



WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER *		REPORT PURPOSE CODE *
		JURISDICTION *	JURISDICTION CLAIM NUMBER *	
		INSURED REPORT NUMBER		OSHA CASE NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION # :		
INDUSTRY CODE	EMPLOYER FEIN	PHONE #		

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN *		CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE	ADMINISTRATOR FEIN *

AGENT NAME & CODE NUMBER: **Donne Insurance Group, Inc**

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION/JOB TITLE	
PHONE		# OF DEPENDENTS	EMPLOYMENT STATUS		NCCI CLASS CODE *
RATE	PER:	DAY WEEK	MONTH OTHER:	AVERAGE WEEKLY WAGES	# DAYS WORKED/WEEK
FULL PAY FOR DAY OF INJURY?		DID SALARY CONTINUE?		YES	NO
				YES	NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE *		PART OF BODY AFFECTED CODE *		
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				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? WERE THEY USED?		YES	NO	NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL OR OFFSITE TREATMENT (NAME & ADDRESS)			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"/> OVERNIGHT HOSPITALIZATION <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
WITNESSES (NAME & PHONE #)			PHONE NUMBER				
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER		